

MARQUETTE AREA PUBLIC SCHOOLS
MEDICATION SELF-ADMINISTRATION PLAN AND AUTHORIZATION (K-12)

Student's Name _____ DOB _____ Grade _____ Teacher/Classroom _____

Date Form Received by School _____

SELF-ADMINISTRATION OF PRESCRIBED INHALERS FOR RESPIRATORY PROBLEMS AND MEDICATION FOR ALLERGIC REACTIONS will be allowed. ALL MEDICATIONS MUST BE IN THE ORIGINAL CONTAINER, clearly labeled, indicating the following information: student's name; name and dosage of medication; method of administration; date issued; and doctor's name.

TO BE COMPLETED BY PARENT/GUARDIAN

I request that (name of child) _____ be allowed to self-administer the medication listed below at school according to school policy.

I understand that:

- (a) my child is responsible for administering his/her medication.
- (b) it is my responsibility to notify the school of change or discontinuation of the medication(s).
- (c) the school is not responsible for determining the number of times the medication is to be used by a student.
- (d) if there is a misuse of the medication, it will be taken away from the student.
- (e) I have the option of requesting school employees to administer the medication listed below in the presence of another adult.

By authorizing self-administration of medication for my child, I waive the option of school employee administration and understand that the building administrator, teacher, or other school employees are not liable for my acts, or the acts of the child in self-administration of this medication.

Signature _____ Relationship _____ Date _____ Phone _____

TO BE COMPLETED BY THE PHYSICIAN/AUTHORIZED PRESCRIBER

Name of medication _____

Reason for medication (OPTIONAL) _____

Form of medication/treatment ___ Tablet/capsule ___ Liquid ___ Inhaler ___ Injection ___ Other

Instructions (schedule and dose to be given at school) _____

Start Date form received _____ Other dates _____

Stop End of school year _____ Other date/duration _____
For episodic/emergency events only

Restrictions and/or important side effects ___ None anticipated ___ Yes, please describe _____

This student is both capable and responsible for self-administering this medication
___ No ___ Yes, Supervised ___ Yes, Unsupervised

This student may carry this medication ___ No ___ Yes

Physician's Name _____

Address _____ Phone _____

Date _____ Signature _____

SCHOOL NURSE'S APPROVAL OF SELF-ADMINISTRATION PLAN

Nurse's Signature _____ Date _____