MENDOCINO COUNTY OFFICE OF EDUCATION
WARREN GALLETTI, SUPERINTENDENT OF SCHOOLS
2240 Old River Road ● Ukiah, CA 95482-6156 ● 707 467-5001 ● Fax 707 462-0379

CHECKLIST FOR STUDENT INDEPENDENT SELF-MEDICATION

STUDENT NAME: ____ **DATE**: ___________________

Staff Initials

______ 1 I have read *Board Policy and Regulation 5035.00 – Student Medication* to the student, especially the *"Independent Self-Medication Authorization"* section.

______ 2 *Student Independent Self-Medication Authorization* form signed by parent/ guardian and doctor.

______ 3 Establish that dosage and instructions are clear for both student and staff. If not clear, then doctor is called for clarification.

______ 4 Notify teacher(s), office staff, and other relevant staff and review confidentiality procedures.

______ 5 Nurse reviews procedure with student and places notice in file that the student is capable.

______ 6 Student has signed the form and read policy on form concerning self-medication.

______ 7 Create a student medical file if no existing file.

______ 8 Parent(s) receive/sent a copy of the *Student Medication* policy and regulation.

______ 9 Place this *Checklist* and the *Authorization* form in the student's medical file.

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AUTHORIZATION FOR STUDENT INDEPENDENT SELF-MEDICATION

(A separate form must be completed by physician for each medication)

Student Name: ____

Date of Birth: ___________________________ School Year: _______________

Physician's Authorization of Medication

The above-named student has my authorization to carry and independently self-administer the following medication. Due to the life threatening circumstances that could result if this student does not have immediate access to this medication, as a physician, I am requesting that this student be allowed to carry and self-administer this medication.

I confirm that this student has been instructed in the proper use of this medication and is able to self-administer this medication on his/her own without school personnel supervision.

Name of Medication:	
Dosage:	
Time and Route:	
Side Effects:	
Reason for Medication:	
Conditions Under Which Medication Is To Be Used:	

Physician Name: (please print)	
Physician Signature:	
Date Signed:	
Physician Address:	
Physician Phone:	

IMPORTANT NOTE*: All medication must be in the container in which it was purchased with the pharmacy label that includes dosage, instructions, and the prescribing physician's name. The medication must be prescribed for the student to whom it will be administered.* ***No medications (including over-the-counter medications) will be given at school without a current prescription from a physician.***

PARENT/GUARDIAN AUTHORIZATION FOR STUDENT INDEPENDENT SELF-MEDICATION

I am the legal guardian of the above-named student. I confirm that the student has been instructed by his/her physician on the proper use of this medication and I approve of my son or daughter's independent self-medication as directed on this form. I also approve of MCOE assisting with the administration of medication, as needed, while at school to him/her as directed by the physician's instructions. I give permission for the school administrator, agency nurse, or other designated school personnel, to consult with the above-named physician regarding any questions about this Authorization.

My child has demonstrated to me that he/she understands the proper use of this medication. He/she is physically, mentally and behaviorally capable to assume this responsibility. If he/she has use of an auto-injectable epinephrine, he/she understands that he/she needs to alert any adult that 911 needs to be called. If he/she has used his/her asthma inhaler as prescribed and does not have relief from an asthma attack, he/she is to alert an adult and seek attention from an appropriate on-site first aide responder.

AUTHORIZATION FOR STUDENT INDEPENDENT SELF- MEDICATION

Student Name: ____

I understand that it is vitally important that the medication being carried by my son or daughter is used only by my son or daughter, and as prescribed. If the he/she knowingly uses the medication other than as prescribed or for purposes other than the diagnosed illness, or should he/she knowingly give the medication to another student; he/she will be subject to disciplinary measures up to and including suspension or expulsion from school and reporting to the appropriate law enforcement agency. Should my son or daughter lose their medication or if someone takes it, he/she must report this to the school office immediately. Failure to report could leave the student subject to disciplinary measures up to and including suspension from school.

I release the agency and school personnel from civil liability if the student suffers any adverse reaction from self - medicating. I will also provide a separate 72-hour supply of medication to be used in case of a disaster occurring during school hours.

My signature below indicates that I have read, understand and fully agree with the above, and that I realize this Authorization is for the current school year only.

____ ____________________

Parent/Guardian's Signature Date

____

Parent/Guardian's Printed Name

STUDENT ACKNOWLEDGEMENT OF AUTHORIZATION FOR SELF-MEDICATION

I certify that I have read and understand the instructions regarding the independent self-administration of my medication and the above statement concerning my responsibilities. I agree to take the medication indicated on this form in compliance with my health care provider's instructions.

____ ____________________

Student's Signature Date

____

Parent/Guardian Printed Name

IMPORTANT: THIS AUTHORIZATION FORM MUST BE DELIVERED IN PERSON BY THE PARENT OR FAXED.
TELEPHONED, STUDENT-DELIVERED OR EMAILED AUTHORIZATIONS WILL NOT BE ACCEPTED. *NO EXCEPTIONS.*

REVIEWED AND APPROVED

____ ____________________

School Nurse's Signature Date

MENDOCINO COUNTY BOARD OF EDUCATION

Adopted: May 11, 2009