Permission for Self Medicating and/or Self Monitoring Medication Packet (Medications such as epipens, inhalers, diabetic devices and medications, life sustaining medications)

Prescription Medications require the ordering provider to complete the order and both the provider and parent signs the order. Please ensure the prescription label matches the orders and is not expired. **All required documentation needs to be in place with the nurse prior to students self carrying medication.**

Please note that there are 4 portions of the self carry medication orders. **2 forms are required to be completed by the medical provider. There is also a parent form and a student form to be completed.**

If the emergency medication is for a **food allergy**, please have the **medical provider complete the Medical Statement to Request Special Meals and/or Accommodations.** This is required to be kept by our cafeteria manager.

For all allergies, please complete the **Allergy History Form.**
For asthma, please complete the **Asthma History Form.**

Please don't hesitate to contact me with questions.

Susan Wright, RN, BSN
Phone: 803-821-0611
Fax: 803-821-0603
Email: swright@lexington1.net

Permission for School Administration of Non-Prescription and Prescription Medication

Lexington County School District One

School Year:_____

For school use only:

❑ Routine

❑ PRN (As needed)

Start Date:_____

Whenever possible, parents/guardians should give their children their medications before or after school hours. The school nurse should not give your child the first (initial) dose of any medication that he or she has never taken before. Please do that at home.

In order for your child to receive any prescription or non-prescription medication, you must completely fill out one of these forms for each medication and give it to the school nurse. **A physician order is required for all prescription medications, all over the counter (OTC) medications that will be administered for >14 consecutive days, all OTC medications outside of the manufacturer's recommendations, and all herbal, dietary or homeopathic supplements or remedies**. All medication must be in its original labeled container. If you were given "samples" of any medications by your health care practitioner, those samples must also be in a container that appropriately identifies the medication.

By signing this form, the parent/guardian and health care practitioner acknowledge that information from this form may be included in the student's Individual Health Care Plan, if applicable. Medications and/or treatments may be administered by an unlicensed, trained district employee.

Child's Name _____ Date of Birth _____

Name of School Child Attends _____ Grade _____

The following section is to be completed by the prescribing health care practitioner for all prescription medications, all OTC medications that will be administered for >14 consecutive days, all OTC medications outside of manufacturer's recommendations, and all herbal, dietary or homeopathic supplements or remedies.

Medication:	Strength:	Dosage:
Indication for medication/Symptoms to treat:	ICD-10 Code:	Route:
Time medication to be given at school: (Lunch times vary from 10:30 a.m.–1 p.m.)	Frequency (e.g., daily):	**ALLERGIES:** (food, insect, medication, etc.)
Anticipated number of days medication will be given at school: ❑ until end of current school year ❑ _____weeks ❑ _____days ❑ _____other (please specify): _____		Note special storage requirements ❑ None ❑ Refrigerate ❑ Other (please specify) Is this medication a controlled substance? ❑ No ❑ Yes
Possible Side Effects:		

Prescribing Health Care Practitioner's Signature _____ Date _____

Stamp, Print or Type Health Care Practitioner's Name and Address:	Office Telephone Number Office Fax Number

The following section is to be completed by child's parent or guardian.

I give permission for my child,_____, to be given the above medication as prescribed. I give permission for the school nurse to contact the health care practitioner named above or the pharmacist who filled the prescription to discuss this medication. I give permission for the health care practitioner named above, the pharmacist and/or their designated employees to provide information about this medication and my child's health to the school nurse. I also give permission for this form to apply if I transfer my child to another school in Lexington County School District One during the current school year. I will not hold the school, school district, or school personnel liable for any adverse drug reactions when the medication is administered according to the prescribed methods. I agree to notify the school if my child's medication changes.

Signature of Parent/Guardian _____ Date _____

Print or Type Name of Parent/Guardian _____ Day Telephone Number _____

LEXINGTON COUNTY SCHOOL DISTRICT ONE

School Health Services Self-Medicating and/or Self-Monitoring

Health Care Provider

When completing this form, draw an "X" through any sections that do not apply. (Example: If the student will not be self-monitoring, draw an "X" through the self-monitoring section.)

This form must be completed by the health care provider who prescribed the student's medication or monitoring device. Note that students will not be permitted to self-administer medications that are classified as controlled substances. Medications must be kept by the student in the container labeled by the pharmacist who filled the prescription. "Sample" medications must be kept in a container that identifies the student and the medication; the container must have a note attached from the health care provider outlining the directions for proper use. An approved individual health care plan is required for students who will self-medicate and/or self-monitor.

Student's Name _____ Date of Birth _____

Name of School _____ Grade _____ Homeroom Teacher _____

Allergies:

Diagnosis/Description of Special Health Care Need:

List the medication(s) related to the student's medical diagnosis that may be self-administered. **Attach specific instructions for how the medication(s) should be used during the school day.**	List monitoring devices related to the student's medical diagnosis that the student may use during the school day. **Attach specific instructions for how the monitoring device(s) should be used during the school day.**
Initial all that apply. All must be initialed in order for the student to be allowed to self-medicate at school. The student named above (a) has been instructed regarding the appropriate use of the medication(s) noted above (i.e., indications, actions, side effects, when to take the medication, when not to take the medication, when to seek assistance)._____ (b) has demonstrated competency for safely self-administering the medication(s) noted above._____ I agree that the student named above should be allowed to possess and self-administer the medication(s) noted above while in the classroom and in any area of the school or school grounds, at any school-sponsored activity, in transit to and from school or school-sponsored activities, and during before-school or after-school activities on school-operated property. _____	Initial all that apply. All must be initialed in order for the student to be allowed to self-monitor at school. The student named above (a) has been instructed regarding the appropriate use of the monitoring device(s) noted above (i.e., indications, interpreting results, safety precautions, simple trouble shooting, when to seek assistance). ____ (b) has demonstrated competency for safely using the monitoring device(s) noted above. _____ I agree that the student named above should be allowed to possess and self-monitor with the device(s) noted above while in the classroom and in any area of the school or school grounds, at any school-sponsored activity, in transit to and from school or school-sponsored activities, and during before-school or after-school activities on school-operated property. _____

Prescribing Health Care Provider's Signature:	Date:
Provider's Printed Name:	Office Phone Number:

EMPOWER ONE
LEXINGTON COUNTY SCHOOL DISTRICT ONE

School Health Services
Self-Medicating and/or Self-Monitoring

Parent/Guardian

When completing this form, draw an "X" through any sections that do not apply. (Example: If the student will not be self-monitoring, draw an "X" through the self-monitoring section.) A new application for self-medicating and/or self-monitoring must be completed each school year. Permission from the student's health care provider is required for self-administration of medications and/or self-monitoring. An approved individual health care plan is also required. Students are not permitted to self-administer medications that are controlled substances.

Student's Name _____ Date of Birth _____

Name of School _____ Grade _____ Homeroom Teacher _____

List the medication(s) that may be self-administered.	**List monitoring device(s) that your child may use during the school day.**
Please read and initial each statement below if you agree. All are required in order for your child to self-administer medications at school. I authorize my child to possess and self-administer the medication(s) noted above as prescribed while in the classroom and in any area of the school or school grounds, at any school-sponsored activity, in transit to and from school or school-sponsored activities, and during before-school or after-school activities on school-operated property. _____ My child has been instructed about the proper use of the medication(s) noted above. _____ My child has shown me that he or she can safely self-administer the medication(s) noted above. _____ My child and I will be responsible for the proper use and safe-keeping of the medication. _____ I will not hold the school district or any of its employees or agents liable if an injury occurs related to my child self-medicating. I will be responsible for any costs related to any claims that occur related to my child self-medicating. _____ I understand that my child will lose the privilege to self-medicate if he or she endangers him- or herself or another student by misusing the medication(s). _____ I understand that my child may only self-administer the medication(s) noted above. All other medications must be given to my child by a school employee. _____ I understand that my child must keep his or her medications in the container provided by the pharmacist or my child's health care practitioner. The container must have my child's name, the name and dosage of the medication, and the directions for proper use on it. ____	**Please read and initial each statement below if you agree. All are required in order for your child to self-monitor at school.** I authorize my child to possess and self-monitor with the device(s) noted above while in the classroom and in any area of the school or school grounds, at any school-sponsored activity, in transit to and from school or school- sponsored activities, and during before-school or after- school activities on school-operated property. ____ My child has been instructed about the proper use of the monitoring device(s) noted above. _____ My child has shown me that he or she can safely use the monitoring device(s) noted above. _____ My child and I will be responsible for the proper use and safe-keeping of the monitoring device(s). _____ I will not hold the school district or any of its employees or agents liable if an injury occurs related to my child self-monitoring. I will be responsible for any costs related to any claims that occur related to my child self-monitoring. _____ I understand that my child will lose the privilege to self-monitor if he or she endangers himself or another student by misusing the monitoring device(s). _____ I understand that my child may only self-monitor with the device(s) noted above. All other devices must be used with the assistance of a school employee. _____

Parent/Guardian Signature _____ Date _____

EMPOWER ONE
LEXINGTON COUNTY SCHOOL DISTRICT ONE

School Health Services Self-Medicating and/or Self-Monitoring

Student

When completing this form, draw an "X" through any sections that do not apply. (Example: If you will not be self-monitoring, draw an "X" through the self-monitoring section.)

Student's Name _____ Date of Birth _____

Name of School _____ Grade _____ Homeroom Teacher _____

List the medication(s) that you will be self-administering.	List the monitoring device(s) that you will be using.
Please read and initial each statement below if you agree. All are required in order to self-administer medications at school. I know when I should and when I should not take the medication(s) noted above. _____ I know the signs and symptoms that may mean that I should not take the medication(s). _____ I know how much of the medication(s) noted above I should take. _____ I know how to take the medication(s) noted above. _____ I will take the medication(s) the way that my health care provider has instructed._____ I will keep the medication in the package provided by the pharmacy or my health care practitioner. _____ I will keep the medication and any supplies needed for taking the medication(s) with me in a safe place. _____ I will not allow other students to touch or hold my medication(s) nor any of the supplies needed for taking the medication. _____ I understand that I will no longer be able to take my medication on my own if I endanger myself or another student by misusing the medication(s)._____ I understand that I can only take the medication(s) noted above on my own. All other medications must be given to me by a school employee. _____	**Please read and initial each statement below if you agree. All are required in order to self-monitor at school.** I know when I should and when I should not use the monitoring device(s) noted above. _____ I know the signs that may mean that the monitoring device(s) is/are not working properly. _____ I know how often to use the monitoring device(s). _____ I will keep the monitoring device(s) and any supplies needed for using the monitoring device(s) with me in a safe place. _____ I will not allow other students to touch or hold my monitoring device(s) nor any of the supplies needed for using the monitoring device. _____ I understand that I will no longer be able to use the monitoring device(s) on my own if I endanger myself or another student by misusing the device(s). _____ I understand that I can only use the monitoring device(s) noted above on my own. All other devices must be used with the assistance of a school employee. _____

Student's Signature _____ Date _____

Parent's/Guardian's Signature _____ Date _____

EMPOWER ONE™
LEXINGTON COUNTY SCHOOL DISTRICT ONE

Dear Parent,

According to your child's health record, he/she has a history of severe allergies. Please complete the information below and return it to the school nurse. Thank you.

Child's Name:_____

Physician:_____ **Phone:**_____

1) List your child's allergies: _____

2) Describe your child's signs and symptoms of an allergic reaction: _____
_____
_____
What is the time frame for your child's reaction? _____
_____

3) List all your child's current medications, including dosage: _____
_____
_____

4) List all emergency medications used to treat your child's allergic reactions, including dose:
_____

5) When and how did you first learn of your child's allergy?
_____
_____
_____

6) Has your child ever been treated in the emergency room or with an Epi-Pen for their allergy? If so, when? _____
_____

7) When was your child's last severe allergy reaction and how did you manage it?
_____
_____

Comments and special instructions.
_____
_____
_____

_____ _____
Parent signature Date

EMPOWER ONE™
LEXINGTON COUNTY SCHOOL DISTRICT ONE

Dear Parent,

According to your child's health record, he/she has a history of asthma. Please complete the information below and return it to the school nurse. Thank you.

Child's Name: _____

Physician: _____ **Phone:** _____

What medication is your child currently taking?

_____

_____

_____

ASTHMA HISTORY

_____ Is there a smoker in any home where the child regularly visits?

_____ What is the number of ER visits for asthma in the last 12 months?

_____ What is the number of hospital admissions for asthma in the last 12 months?

_____ What is the number of urgent doctor visits for asthma in the last 12 months?

_____ What is the number of oral steroid pulses in the last 12 months?

_____ How many times was rescue medicine (example, Albuterol) used in the last week?

_____ How many days was your child absent from school in the last 3 months, which were related to asthma?

_____ How many coughing episodes per day in a one-month period does your child have?

_____ How many night awakenings did your child have in the last month?

_____ How many times was your child unable to participate in gym in the last three months?

Comments and special instructions (asthma triggers, activity restrictions, etc.)

_____

_____

_____

_____

_____ _____

Parent signature Date

MEDICAL STATEMENT TO REQUEST CHILD NUTRITION PROGRAMS SPECIAL MEALS AND/OR ACCOMMODATIONS

1. School/Agency Name	2. Site Name	3. Site Telephone Number

4. Name of Participant	5. Age or Date of Birth

6. Name of Parent or Guardian	7. Telephone Number

8. Check One:

☐ Participant has a disability, which may include a food allergy, and requires a special meal or accommodation. Schools and agencies must make reasonable modifications to the meal to accommodate a disability which restricts a participant's diet. Modifications during and for food service may be required. Schools and agencies participating in federal nutrition programs must comply with requests for special meals. **A licensed physician, physician's assistant, or nurse practitioner must sign this form.**

☐ Participant does not have a disability, but is requesting a special accommodation for a **fluid milk substitute** that meets the nutrient standards for non-dairy beverages offered as milk substitutes. **Food preferences are not an appropriate use of this form.** Schools and agencies participating in federal nutrition programs are encouraged to accommodate reasonable requests. **A licensed physician, physician's assistant, nurse practitioner, parent, or guardian may sign this form.**

9. If participant has a disability, provide a brief description of participant's major life activity affected by the disability:

10. Diet prescription and/or accommodation: (*please describe in detail to ensure proper implementation-use extra pages as needed*)

11. Indicate texture:

☐ Regular ☐ Chopped ☐ Ground ☐ Pureed

12. Schools and agencies are not required to provide the exact substitution or other modification requested. However, must offer a reasonable modification that effectively accommodates the participant's disability and provides equal opportunity to participate in or benefit from the federal nutrition programs.

Foods to be omitted and available/acceptable substitutions: (*please list specific foods to be omitted and suggested substitutions. you may attach a sheet with additional information as needed*)

A. Foods To Be Omitted	B. Available/Acceptable Substitutions

13. Modifications to meal service:

14. Signature of Preparer*	15. Printed Name	16. Telephone Number	17. Date

18. Signature of Medical Authority**	19. Printed Name	20. Telephone Number	21. Date

***Parent/legal guardian signature is acceptable for fluid milk substitution for a child with dietary needs other than a disability.**

****Medical Authority's signature is required for participants with a disability.**

The information on this form should be updated to reflect any changes to the current medical and/or nutritional needs of the participant, and updated annually.