CROMWELL PUBLIC SCHOOLS

AUTHORIZATION FOR THE SELF-ADMINISTRATION OF MEDICATION FOR THE EMERGENCY TREATMENT OF SEVERE ALLERGIC REACTIONS

Physician's/Dentist's/Advanced Practice Registered Nurse's/Physician Assistant's Orders

Name of Student: _____ Date: _____

Address: _____ DOB: _____

Condition for which drug is being administered: _____

1) Name of Drug (including generic name): _____

Dose: _____ Frequency: _____

Relevant side effects and management: _____

Medication shall be administered from _____ (date) to _____ (date)

2) Name of Drug (including generic name): _____

Dose: _____ Frequency: _____

Relevant side effects and management: _____

Medication shall be administered from _____ (date) to _____ (date)

Self Administration:

1. I have conferred with this child's parents/guardians and feel this medication may be self-administered.
2. This student has been appropriately instructed regarding self-medication.

Physician's/Dentist's/APRN's/PA's Name: _____ Telephone #: _____

Address: _____

Physician's/Dentist's/APRN's/PA's Signature: _____ Date: _____

PERMISSION OF PARENT/GUARDIAN FOR SELF-ADMINISTRATION OF MEDICATION FOR THE EMERGENCY TREATMENT OF SEVERE ALLERGIC REACTIONS

- I herby request that the above medication, ordered by the physician/dentist/APRN/PA of my child, _____ _____, be administered by my child. I assume responsibility for granting permission for my child to self-administer medication as approved and instructed by the physician/dentist/APRN/PA.
- I understand that I must supply the nurse with back-up medication in the event the medication is lost or misplaced by my child.
- I understand this medication will be destroyed if it is not picked up on the last day of school.
- I give permission for the exchange of information between the prescriber and the School Nurse necessary to ensure the safe administration of such medication.

Name: _____ Date: _____

Signature: _____ Emergency Telephone #: _____

STUDENT AGREEMENT FOR SELF-ADMINISTRATION OF MEDICATION

I understand that I may use my medication for the emergency treatment of a severe allergic reaction as prescribed by my doctor. I will not use it in any other way. I will not let any other person use my medication. I will notify my school nurse/school personnel trained in the administration of medication immediately so that 911 can be called. I understand that if I do not follow these rules, I will not be allowed to self-medicate.

Signature of Student: _____ Date: _____