THE PATHWAYS SCHOOLS

INFORMATION FOR SELF ADMINISTRATION OF MEDICATIONS BY STUDENTS IN SCHOOL

1. No medication will be administered in school or during school-sponsored activities without the parent's/ guardian's written authorization and a written authorized prescriber order. This includes both prescription and over-the-counter (OTC) medications.
2. *The Pathways Schools School Medication Self Administration Authorization Form* must be completed for medication administration in school.
3. The parent/guardian is responsible for obtaining the authorized prescriber's authorization. This is required every school year for each new or continuing order or if there is a change in dosage or time of administration during the school year.
4. The medication must be delivered to the school by the parent/guardian or, under special circumstances, an adult designated by the parent/guardian.
5. All prescription medication must be provided in a container with the pharmacist's label attached. Nonprescription OTC medication must be in the original container with the manufacturer's dosage label and safety seal intact.
6. The parent/guardian is responsible for collecting any unused portion of a medication within one week after expiration of the authorized prescriber's order or at the end of the school year. Medication not claimed within that time period will be destroyed.
7. An authorized prescriber's order and parent/guardian permission are necessary for self carry/self administered emergency medications such as inhalers for asthma and epinephrine auto injector for anaphylaxis. **The authorized prescriber must evaluate and approve the student's ability and capability to self administer medication. It is imperative the student understands the necessity for reporting to the staff that they have self administered their inhaler without any improvement or have self administered an epinephrine auto injector, so it can be determined if 911 should be called.**
8. A school administrator or designee will call the authorized prescriber, as allowed by the *Health Insurance Portability and Accountability Act* (HIPAA), if a question arises about the student and/or the student's medication.

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SCHOOL MEDICATION SELF ADMINISTRATION AUTHORIZATION FORM

This order is valid only for school year (current) _____ including the summer session.

School: __The Pathways School___ Site:_____

This form must be completed fully in order for schools to monitor the self-administration of the required medication. A new medication self administration form must be completed at the beginning of each school year, for each medication, and each time there is a change in dosage or time of administration of a medication.

* IMPORTANT - Whenever possible please have medication given at home, before or after school.
* ALL MEDICATIONS ARE SELF-ADMINISTERED BY STUDENTS WHILE MONITORED BY TRAINED STAFF.
* Prescription meds must be in a properly labeled container. Non-prescription meds must be in original container with the label intact.
* An adult must bring the medication to the school.

Prescriber's Authorization

Name of Student: _____ Date of Birth: _____ Grade: _____

Condition for which medication is being self administered: _____

Medication Name: _____Dose: _____Route: _____

Time/frequency of self administration: _____ If PRN, frequency: _____

If PRN, for what symptoms: _____

Relevant side effects: ☐ None expected ☐ Specify: _____

Medication shall be self administered from: _____to_____
Month / Day / Year Month / Day / Year

Prescriber's Name/Title:_____
(Type or print)

Telephone: _____FAX: _____

Address:_____

_____

Prescriber's Signature: _____Date:_____
(Original signature or signature stamp ONLY)

(Use for Prescriber's Address Stamp)

A verbal order was taken by a school administrator (Name): _____ for the above medication on (Date): _____

PARENT/GUARDIAN AUTHORIZATION

I request designated school personnel to monitor the self administration of the medication as prescribed by the above prescriber. I certify that I have legal authority to consent to medical treatment for the student named above, including the self administration of medication at school. I understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded. I authorize a school administrator or designee to communicate with the health care provider as allowed by HIPAA.

Parent/Guardian Signature: _____ Date: _____

Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____

SELF CARRY/SELF ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL

Self carry/self administration of **emergency** medication such as inhalers and epinephrine auto-injectors must be authorized by the prescriber.

Prescriber's authorization for self carry/self administration of emergency medication: _____
Signature Date

School administrator approval for self carry/self administration of emergency medication: _____
Signature Date