

LOS LUNAS PUBLIC SCHOOLS

AUTHORIZATION AND PROTOCOL FOR SELF-ADMINISTERED MEDICATION

Name of Student _____

Date of Birth _____ Grade _____ School _____

In order for your child to carry a self-administered emergency medication on his/her person, the following must be understood and agreed upon by the student and parents:

1. The student may utilize the prescribed self-administered medication as needed and directed by his/her health care provider.
2. The doctor's signature indicates the student has been instructed on the proper use of the prescribed medication.
3. The medication must be properly labeled with the student's name.
4. Both the Authorization for Prescribed Medication form and this Protocol must be signed by the parent/guardian and placed on file at the school prior to your child carrying a self-administered medication on his/her person.
5. **INHALER: NO DIRECT MONITORING** will be conducted by the school staff. The student is responsible for self-administration of the inhaler. If the student continues having difficulty breathing, he/she should report to the health office and the parents will be notified by the appropriate school staff.
6. **SELF-ADMINISTERED EMERGENCY EPINEPHRINE: NO DIRECT MONITORING** will be conducted by the school staff. The student is responsible for notifying school staff in the event he/she had the need to self-administer the emergency medication.
7. **DIABETIC MEDICATION AND SUPPLIES: NO DIRECT MONITORING** will be conducted by the school staff. The student is responsible for recognizing the signs of hypoglycemia or hyperglycemia and notifying an adult.

A Prescribed Diabetic Management Plan must be on file signed by the health care provider, parent/guardian, and the student.

Supplies, including insulin, will be the responsibility of the parent/guardian and the student. A *sharps* container is mandatory to dispose of lancets and needles.

Emergency supplies for *hypoglycemia and/or hyperglycemia* will be kept in the health office during the school year and are the responsibility of the parent/guardian and the student.
8. The parent/guardian will immediately notify the school if the child's health status changes, or when a change in health care provider and/or medication occurs. Changes in procedure must be received in writing from the health care provider authorizing treatment.
9. The Los Lunas Public Schools will not assume any risk involved with improper handling of this medication including: overuse, improper administration, breakage, theft, loss, sharing, playing with or careless storage of medication.
10. Re-evaluation of the present protocol may be needed if the student is found to display behavior that increases the safety risks of him/her self or the students on campus.
11. This agreement shall remain in effect until written notice to terminate the agreement is received and acknowledged in writing by the school principal. If this agreement is terminated by either the parent or school principal, the child will no longer be authorized to carry and/or self-administer any medication at school.

Principal _____ Date _____

Parent/Guardian _____ Date _____

School Nurse _____ Date _____

PERMISSION TO CARRY AND SELF-ADMINISTER
TO BE COMPLETED BY HEALTH CARE PROVIDER

Name of Student _____

Date of Birth _____

Medication _____

The above-named student has been instructed in the proper use of their asthma inhaler/diabetic supplies/emergency medication. The child's well-being is in jeopardy unless this medication is carried on his/her person.

Therefore, I request that he/she be permitted to carry the asthma inhaler/diabetic supplies/emergency medication at school. He/she is capable of self-administering the medication, understands the purpose, appropriate method, and frequency of use of the asthma inhaler/diabetic supplies/emergency medication.

Health Care Provider _____ Date _____

(Print Name) _____ Telephone _____

TO BE COMPLETED BY THE PARENT/GUARDIAN

I permit my child to carry the above-listed asthma inhaler/diabetic supplies/emergency medication as ordered by his/her health care provider. I also specifically release, hold harmless and indemnify the Los Lunas Public school district and all school personnel from any and all civil liability for personal injuries or property damages that may be the result of Los Lunas school district permitting my child to self-administer his/her own medication without the assistance or supervision of the District.

Parent/Guardian _____ Date _____

TO BE COMPLETED BY THE STUDENT

I have been instructed in the proper use of my medication and will take it as prescribed to me by my health care provider. I understand that using my medication in a manner other than as prescribed by my health care provider can result in disciplinary action taken against me by my school _____ and/or Los Lunas Public School District.

Student signature _____ Date _____

The above named student has demonstrated the ability to self-assess and self-administer their medication(s).

School Nurse _____ Date _____