



Dorchester
School District 4

DOCTORS' ORDERS

SCHOOL YEAR _____

Student Name _____ Self Medicating _____ Self-Monitoring _____ Both _____
DOB _____

School _____ Grade _____ 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 device(s) 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.

The student name above:

- (a) Has been instructed regarding the appropriate use of the medication(s) noted above (e.g. 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 medications noted above.

The student name above:

- (a) Has been instructed regarding the appropriate use of the monitoring device(s) noted above (e.g., indications, interpreting results, safety precautions, simple troubleshooting, 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 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 activities, and during before-school or after-school activities on school operated property.

I agree that the student named above should be allowed to 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 during after-school activities on school operated property.

Prescribing Healthcare Provider's Signature

Date:

Provider's Printed Name:

Office Phone Number:



PARENT/GUARDIAN

Self Medicating

Self-Monitoring

Both

Student Name _____

DOB _____

School _____ **Grade** _____ **Teacher** _____

A new application for self-medicating and/or self-monitoring must be completed each school year. Students are not permitted to self administer medications that are controlled substances. Permission from the student's healthcare provider is required for self administration of medications and self-monitoring. All medications must be kept in the container labeled by the pharmacist who filled the prescription. "Sample" medications must be kept in a container that identifies the medication and must have a note attached from the student's healthcare provider outlining the directions for proper use.

<p>Only the medications approved by your physician may be self-administered.</p>	<p>Only the monitoring device(s) listed by your physician may be self-monitored during the school day.</p>
<p>PARENT, please read and initial each statement below if you agree. All are required in order for your child to self-administer medications at school.</p> <p>I authorize my child to 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.</p> <p><u>My child has been instructed about the proper use of the medication(s) noted above.</u></p> <p><u>My child has shown me that he/she can safely self-administer the medication(s) noted above.</u></p> <p><u>My child and I will be responsible for the proper use and safe-keeping of the medication.</u></p> <p><u>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.</u></p> <p><u>I understand that my child will lose the privilege to self-medicate if he/she endangers himself or another student by misusing the medication(s).</u></p> <p><u>I understand that my child may only self-administer the medications(s) noted above. All other medications must be given to my child by the school nurse or school employee.</u></p>	<p>PARENT, please read and initial each statement below if you agree. All are required in order for your child to self-monitor at school.</p> <p>I authorize my child to self-monitor with the device(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.</p> <p><u>My child has been instructed about the proper use of the monitoring device(s) noted above.</u></p> <p><u>My child has shown me that he/she can safely use the self-monitoring device(s) noted above.</u></p> <p><u>My child and I will be responsible for the proper use and safe-keeping of the monitoring device(s).</u></p> <p><u>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.</u></p> <p><u>I understand that my child will lose the privilege to self-monitor if he/she endangers himself or another student by misusing the monitoring device(s).</u></p> <p><u>I understand that my child may only self-monitor with the device(s) noted above. All other monitoring device(s) must be used with the assistance of the school nurse or a school employee.</u></p>



Dorchester
School District 4

STUDENT

Self Medicating

Self-Monitoring

Both

Student Name _____

DOB _____

School _____

Grade _____

Teacher _____

Only the medications approved by your physician may be self-administered.

Only the monitoring device(s) listed by your physician may be self-monitored during the school day.

STUDENT, please read and initial each statement below if you agree. **All** are required in order for your child to self-administer medications at school.

STUDENT, please read and initial each statement below if you agree. **All** are required in order for your child to self-monitor at school.

I know when I should and when I should not take the medication(s) noted above.

I know when I should and when I should not use the monitoring device(s) noted above.

I know the signs and symptoms that may mean that I should not take the medication(s). _____

I know the signs that may mean the monitoring device(s) is/are not working properly. _____

I know how much of the medication(s) noted above, I should take. _____

I know how to take the medication(s) noted above.

I know how often to use the monitoring device(s). _____
I will keep the monitoring device(s) with me in a safe place. _____

I will take the medication(s) the way that my healthcare provider has instructed. _____

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 will keep the medication in the package provided by the pharmacy or my healthcare provider. _____

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 use the monitoring device(s) on my own if I endanger myself or another student by misusing the device(s). _____

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 use the monitoring device(s) noted above on my own. All other devices must be used with the assistance of the school nurse or a school employee. _____

I understand that I can only take the medication(s) noted above on my own. All other medications must be given to me by the school nurse or a school employee. _____

STUDENT SIGNATURE _____

DATE _____

PARENT SIGNATURE _____

DATE _____