NOTE: SELF CARRY PERMISSION FORM ONLY!

HARFORD COUNTY PUBLIC SCHOOLS
PERMISSION FOR STUDENTS TO CARRY/SELF ADMINISTER MEDICATIONS

It is the policy of the Harford County Public Schools to prohibit students from possessing or using prescription or over-the-counter medication on school buses or on school property. Note: **a student may NOT carry pills, capsules or liquid medication** at any time. However because of a serious medical condition, a student may need to carry an inhaler for asthma or EpiPen® for severe bee sting or allergic reactions. If the health care provider feels that your child must carry and self-administer either an inhaler or EpiPen®, please have the health care provider sign this form, stating the **medical necessity** for carrying the medication. Parent/guardian must also sign the form. This completed form must be given to the school nurse. The school nurse will notify all appropriate personnel when such exceptions are granted, including bus drivers. A copy of this form will be retained in the student's confidential health folder. The Contract for Self-Administration of Medication on the reverse side must also be completed.

HEALTH CARE PROVIDER INSTRUCTIONS FOR GIVING MEDICATION IN SCHOOL

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

Allergies: _____

Medication Name: _____ Route: _____

Reason for Administration: _____

Exact Dose to be Given **(Must specify in mg and/or # of puffs)** _____

Time/Frequency of Administration: _____ If prn, frequency: _____

If prn, for what observable signs & symptoms:_____

Medical necessity to self carry: (please specify)_____

Duration of Administration: _____

Relevant Side Effects: None Expected _____ Specify: _____

Any additional instructions or follow-up: _____

Health Care Provider Signature: **(no stamps)** _____ Date: _____

Health Care Provider Name Printed _____

Phone: _____ Fax: _____

PARENT/LEGAL GUARDIAN AUTHORIZATION

- I request designated school personnel to administer the medication as prescribed by the above health care provider.
- I certify that I have legal authority to consent to medical treatment for the student named above, including the administration of medication at school.
- I authorize the school nurse to communicate with the health care provider as needed.

Parent/Legal Guardian Signature:_____

Date: _____ Phone: _____ (OVER)

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School:_____ Grade:_____ Sch Yr:_____ DOB:_____	**CONTRACT FOR SELF ADMINISTRATION OF MEDICATION** _____ Student Name	Authorization Dates:_____ Authorized Health Care Provider: _____ Parent/Guardian:_____ _____

This Medication Contract has been designed to ensure student safety and well-being. Persons indicated below will assume designated responsibilities in an agreement which allows this student to:

Self administer_____
(Name of Medication) (Specify Time or When Needed)

		Nurse Date/Initial
The Parent / Guardian will…	**Provide** written parent /guardian and Health Care Provider authorization – and – Monitor/Verify that student takes medication as prescribed knowing that school personnel cannot monitor self-administration. **Provide** back-up medication in Health Suite for emergency use. **Inform** School Nurse within 24 hours of any change in medication treatment regime. **Contact** School Nurse in May/June to discuss plan for the next school year. **Authorize** telephone communication between School Nurse and authorized health care provider as needed.	
The Student will…	**Demonstrate/Explain** to School Nurse, correct use of the medication including frequency. **Store** medication safely along with a copy of this Contract . **Take** medication independently and discreetly – and – keep parent /guardian and School Nurse informed. **Notify** Health Suite immediately if medication is lost or stolen. **Agree** to **NOT** share medication with other students (this is subject to disciplinary action). **Other:** _____	
The School Nurse will…	**Develop** the authorized Medication Contract and any related individualized Nursing Health Care Plan. **Inform** appropriate school personnel (such as Office Staff, Teachers, Bus Drivers, etc.).	
Other "Need to Know Personnel" will…	**Be Aware** of the student's Medication Contract. **(For Classroom Teachers,** leave information for any substitute teacher.) **Report** unusual circumstances to Health Suite immediately.	

VERIFICATION OF MEDICATION CONTRACT

"Need to Know Personnel" will be informed of Medication Contract by School Nurse.

_____
School Nurse Signature Date

If non-compliance or a change in status occurs, an Administrator, the student, parent/guardian or School Nurse may call for an immediate review. We have read and agreed to the contents of this Medication Contract:

_____ _____
Student Signature Date Parent /Guardian Signature Date