School Health Care Services
Medication Self-Administration Plan

Please note that self-administration is usually reserved for the following: inhalers, glucose monitoring tests, and insulin delivery systems. Once completed and signed, this form is to be copied and given to the student for whom self-administration is determined to be appropriate. The original is to be retained by the school nurse in the medication book. The medication is to be entered and recorded in the computerized health record for inclusion in the medication statistics.

Student Name: _____ Grade: _____
Medication to be taken: _____ When: _____ Route: _____
Instructions for administration:

_____
_____
_____

Amount of medication to be carried by the student: _____
How/Where will medication be carried by the student? Backpack ☐
Pocketbook/waist pack ☐
Replenishing of medication to be done: In Nurse's Office ☐
At home ☐
When should student go to the Nurse's Office? At the end of each school day ☐
At the end of each week ☐
When the medication orders change ☐
If I have the following side effects/symptoms, I should go to the Nurse's Office:

_____
_____
_____
_____

Nurse's Signature/Date: _____

Student's Signature/Date: _____

Parent/Guardian Signature/Date: _____

Plan Discontinuation: Date: _____ Reason: _____
Signature: _____

MEDICATION ADMINISTRATION PLAN (To be completed by the school nurse)
Medication: Date Ordered:
Expiration Date: _____ Time to be given: _____
IHCP: Yes/No Refrigerate: Yes/No Order received/pharmacy label copied: Yes/No

Nurse's Signature/Date: _____