Willard Public Schools
Focused | Connected | Driven

SELF-ADMINISTRATION FORM

_____ _____
Name of Student Grade/Teacher

_____ _____
Name of Physician Physician's Phone Number

_____
Name of Medication Dosage Time

Medication must be dispensed according to Willard Public Schools Medication Policy.
The medication must be labeled with student's name.

RESPONSIBILITIES FOR CARRYING RESPIRATORY INHALERS or EPI-PEN.

OBSERVED YES	NO	
____	____	Action Plan returned
____	____	Demonstrates correct use of medication
____	____	Describes proper timing for medication use
____	____	Understands not sharing medication with other students
____	____	Will keep medication on person
____	____	Agrees to come directly to the Health Office if having difficulty with breathing, wheezing, or is experiencing chest tightness after using medication

THE STUDENT ***DOES / DOES NOT*** DEMONSTRATE MEETING THE ABOVE SPECIFIED RESPONSIBILITIES.

THE PRIVILEGE OF CARRYING THE MEDICATION ***WILL / WILL NOT*** BE ALLOWED.

_____ _____
Student Signature Date RN/LPN Signature Date

COMMENTS: _____

_____

MY CHILD WILL BE RESPONSIBLE FOR CARRYING THIS MEDICATION AND WILL SELF-ADMINISTER. MY CHILD AGREES TO FOLLOW THE DISTRICT'S PROCEDURES CONCERNING THE HANDLING AND ADMINISTRATION OF THIS MEDICATION.

Parent/Guardian Signature_____ Date_____