Bourne Public Schools
Medication Self Administration Plan

Directions: 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/Homeroom:** _____

Medication to be Taken: **When:** _____ **Route:** _____

Instructions for Administration: _____

_____

Amount of medication to be carried by Student: _____

How/Where will medication be carried? **Backpack** **Pocketbook/Waistpack** **Pocket**

Replenishing of medication to be done? **At home** **In Nurse's Office**

When should I [student] go to the Nurse's Office? **At the end of each school day**

At the end of the week

When my medication, dose or frequency changes

If I have the following side effects/symptoms

_____

_____

Other: _____

_____

_____

Nurse's Signature / Date: _____

Student's Signature / Date: _____

Parent / Guardian's Signature / Date (if appropriate) _____

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

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