Old Colony RVTHS
Student Self Administration Medication Plan

<u>Direction:</u> 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 Student:_____

Where will the medication be carried? Backpack, Pocketbook, Pocket, Other_____

Replenishment of the 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, frequency change

If I have the following side effects/symptoms:
_____
_____

Other:_____
_____

Nurse's Signature/Date:_____

Student's Signature/Date:_____

Parent/Guardian's Signature/Date_____

Plan Discontinuation Date:_____ Reason:_____ Signature; _____

Revised 3/16/2023