AIKEN COUNTY PUBLIC SCHOOLS

Aiken County School Health Services
Self-Medicating and/or Self-Monitoring
Health Care Practitioner Authorization

When completing this form, draw an "X" through any sections that do not apply. (Example: If the student will not be self-monitoring draw an "X" through the self-monitoring section.)

This form must be completed by the health care practitioner who prescribed the student's medication or monitoring device. Note that students will not be permitted to self-administer medications that are classified as controlled substances. Medications must be kept by the student in the container labeled by the pharmacist who filled the prescription. "Sample" medications must be kept in a container that identifies the student and the medication; the container must have a note attached from the health care provider outlining the directions for proper use.

_____ _____
Student's Name Date of Birth

_____ _____ _____
Name of School Grade Homeroom Teacher

Allergies:

Diagnosis / Description of Special Health Care Need:

List the medication(s) related to the student's medical diagnosis that may be self-administered. **Attach specific instructions for how the medication(s) should be used during the school day.**	List monitoring devices related to the student's medical diagnosis that the student may use during the school day. **Attach specific instructions for how the monitoring device(s) should be used during the school day.**
Initial all that apply. All must be initialed in order for the student to be allowed to self-medicate at school. The student named above: (a) has been instructed regarding the appropriate use of the medication(s) noted above (e.g., indications, actions, side effects, when to take the medication, when not to take the medication, when to seek assistance). _____ (b) has demonstrated competency for safely self-administering the medication(s) noted above. _____ I agree that the student named above should be allowed to self-administer the medication(s) noted above while in the classroom and in any area of the school or school grounds, at any school-sponsored activity, in transit to and from school or school-sponsored activities, and during before-school or after-school activities on school-operated property. _____	Initial all that apply. All must be initialed in order for the student to be allowed to self-monitor at school. The student named above: (a) has been instructed regarding the appropriate use of the monitoring device(s) noted above (e.g., indications, interpreting results, safety precautions, simple trouble shooting, when to seek assistance). _____ (b) has demonstrated competency for safely using the monitoring device(s) noted above. _____ I agree that the student named above should be allowed to self-monitor with the device(s) noted above while in the classroom and in any area of the school or school grounds, at any school-sponsored activity, in transit to and from school or school-sponsored activities, and during before-school or after-school activities on school-operated property. _____

Prescribing Health Care Provider's Signature:	Date:
Provider's Printed Name:	Office Phone Number: