Houston Independent School District
Health and Medical Services

Policies Governing Self -Administration of Emergency Medication for Treatment of Asthma, Anaphylaxis and Diabetes while on School Property or a School Related Activity

District policy allows a student at risk for anaphylaxis or a diagnosis of asthma, or diabetes to possess and self-administer prescription medicine for management of their care under certain conditions.
This form must be filled out completely to allow students with these conditions to possess and self-administer prescription medicine. A new medication form must be completed at the beginning of each school year for each prescription medication, and each time there is a change in the medication's administration instructions.
It is important to note the following:

- By signing below, the health care provider and parent confirms that the student is capable of self-administration of the medication.
- The School Nurse may re-evaluate the student's ability to self-administer medications as needed
- Self-administration orders must be included in the Diabetes Medical Management Plan (DMMP) for students with diabetes.
- This serves as an exception to the HISD medication policy that requires all medications to be kept in a locked area in the nurse's office.

Student's Name ______________________________ Sex__________

Date of Birth _____ / _____ / _____ Name of School ______________________________

Medical Diagnosis: ______________________________ ☐Infectious □Non-Infectious □Allergy

Medication Name: ______________________________

Dose (amount to be given): ______________________________

Frequency (how often): ______________________________

Form of Medication (Route): ______________________________

☐tablet ☐pill ☐capsule ☐liquid ☐inhalation ☐injection

☐ other (specify): ______________________________

Possible side effects ______________________________

Student has demonstrated that they can self-administer their medication Yes No

If NO, please explain other support needed to achieve independence ______________________________

This is permission for my child named above to self-carry medication requested by the physician. I understand that I am giving consent for the school nurse to discuss any concerns regarding this medication with the healthcare provider whose signature appears on this document to monitor the healthcare needs of my child.

____
Parent's Signature

____
Telephone:

____
Date:

____
Physician's/Advanced Practice Nurse Signature

____
Physician's/Advanced Practice Nurse Name (print or type)

____
Date

____
Facility Name

____
Telephone