SELF MEDICATION ASSESSMENT

Student: ___________________________________ Student ID #:___________ School: _________

D.O.B.: _________________________ Age: _______________

Physical/Behavioral Limitations: ____

Name of Medication: ____

Self-Medication Criteria:

A. Student is capable of identifying individual medication. [ ] Yes [ ] No

Comments: ____
____

B. Student is knowledgeable of the purpose of individual medication. [ ] Yes [ ] No

Comments: ____
____

C. Student is able to identify/associate specific symptom occurrence and need for medication administration. [ ] Yes [ ] No

Comments: ____
____

D. Student is capable and knowledgeable of medication dosage. [ ] Yes [ ] No

Comments: ____
____

E. Student is knowledgeable about method of medication administration. [ ] Yes [ ] No

Comments: ____
____

F. Student is able to state side effects/adverse reactions to his/her medication. [ ] Yes [ ] No

Comments: ____
____

G. Student is knowledgeable of how to access assistance for self if needed in an emergency. [ ] Yes [ ] No

Comments: ____
____

H. Student understands his/her responsibility for transporting and carrying medication.
[ ] Yes [ ] No

Comments: ____

____

Based on Assessment:

[ ] Student is not a candidate for self-medication program a time.

[ ] Student is a candidate for self-medication program with supervision.

[ ] Student has successfully completed self-medication training and demonstration of self-medication.

Comments: ____

____

Student Signature of Compliance ________________________ Date: ______________

Parent acknowledges responsibility of student and all medications regulations while at school

Parent Signature: ________________________________ Date: _____________________

School Nurse: ___________________________________ Date: _____________________

Person Responsible for monitoring student compliance ______________________________

Principal/Teacher Notified:

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