Assessment for Determination of Supervised Student

New York State ***Guidelines for Medication Management in Schools 2015*** allows students who have been determined to need supervision either by the school nurse or the student's provider to be assisted by trained unlicensed personnel to self-administer their own medication. The supervised student can complete the tasks below to take their own medication under supervision. At the student's direction, he/she may request assistance such as opening or pouring from bottles, assembling nebulizer tubing, verifying the student's math calculations and the number entered into an insulin pump as needed.

Name:	Medication:	Grade:
Teacher/HR	DOB:	Date:

This student can independently complete the following:

Administer the medication to him/herself via the correct route *Comments:*	**YES** ☐	**NO** ☐
Recognize this medication (e.g., color, shape, size) *Comments:*	**YES** ☐	**NO** ☐
Determine the correct dosage which is needed (e.g., one tablet, 2 puffs, 3 units, etc.) *Comments:*	**YES** ☐	**NO** ☐
Identify the time this medication is needed during the school day (e.g., lunch time, before/after lunch, before PE class) *Comments:*	**YES** ☐	**NO** ☐
Describe how to take this medication from original labeled pharmacy container or original OTC container and administer it to themselves (or is able to direct staff member to assist) by the correct route (e.g., oral, nasal, inhaled, topical) *Comments:*	**YES** ☐	**NO** ☐
Describe why (purpose) this medication is taken and under what circumstances it is appropriate to do so (e.g., to improve attention. blood glucose or vital sign ranges that are acceptable to take medication, taken only for headache, shortness of breath, etc.) *Comments:*	**YES** ☐	**NO** ☐
Describe what happens when this medication is not taken (e.g., unable to complete school work, blood glucose will elevate, etc.) *Comments:*	**YES** ☐	**NO** ☐
Describe when to refuse to take this medicine when appropriate (wrong color, shape, amount, duplicate dose) *Comments:*	**YES** ☐	**NO** ☐

☐ **This student meets the criteria of being self-directed.**

☐ **This student does not meet the criteria of being self-directed.**
Plan to assist student in becoming self-directed and date of reassessment: ____________

Medical Provider:		Date:
Phone #:	Fax:	

☐ **(Optional) Copy shared with parent on ___________**