School Health Services

DETERMINATION OF SELF-DIRECTED STUDENTS

Student Name: _____ Grade: _____

Date: _____ Classroom Teacher: _____

Medication: _____

Dose: _____

_____

Reason for Medication**:** _____

THIS STUDENT:

Recognizes his/her medication *Comments:*	**YES**	**NO**
Knows how much medication he/she takes *Comments:*	**YES**	**NO**
Knows what time his/her medication is needed during the school day *Comments:*	**YES**	**NO**
Knows why he/she takes this medication *Comments:*	**YES**	**NO**
Knows what happens when he/she doesn't take their medication *Comments:*	**YES**	**NO**
Knows when to refuse to take his/her medicine when appropriate *Comments:*	**YES**	**NO**

- ☐ **This student meets the criteria to be determined to be self-directed.**
- ☐ **This student does <u>not</u> meet the criteria to be determined to be self-directed.**

Plan to assist student in becoming self-directed: _____

_____

_____

Prescriber's Signature: _____ **Date:** _____

Parent's Signature: _____ **Date:** _____

School Nurse Signature: _____ **Date:** _____