

Medication Self-Carry Agreement

Student Nam	dent Name: Birthdate:	
Grade/Teach	er	
 Medication if St A M A do pl v ac Pe A 	the following criteria are met tudents must be 12 years old. one day supply of medication ledication is in the original consequence. Prescription- labels must medication, dosage, rout Non-prescription- medication the original container. Check to see it is current request form signed and dated osage, date(s), and times(s) taken hysician's permission to self-critical iolations of any conditions pladministering medication may remission and forms are good student under 12 years of age	ntainer a specify the name of student, name of e and frequency or time of administration ation must have the student's name written or a or unexpired by the parent indicating name of medication en. Prescription medication must also have a arry and signature. ced on the student carrying and self esult in termination of that permission.
Medication:		Dose:
Reason for ta	king medication:	
Time:	Dates:	Current school year
Parent Signature:		Date:
School Nurse Signature:		Date:
ApaIfprIf	articipating in, before and/or as symptoms are not relieved in roceed with escort to health ro- medication is lost at school, s	be brought on all field trips and while fter, school activities 15 minutes, student will notify staff and
Student Signature:		Date:

School Nurse Signature: ______ Date: _____