CONTRACT FOR SELF-CARRIED MEDICATION

Student: ______________________________ Grade: __________

Physician: ____________________________ Telephone: ____________________

Medication: ___________________________ Dose: ____________ Time: __________

Medication is permitted in accordance with district policy. Student's physician must authorize self-carried/administered medication. Student name must appear on the medication container or inhaler.

Responsibilities for carrying medication:
Yes No
___ ___ Health care action plan complete
___ ___ Demonstrated correct use/ administration
___ ___ Recognizes proper and prescribed timing for medication
___ ___ Does not share medication with others
___ ___ Keeps medication in agreed location
___ ___ Keeps second labeled container in the Health office
___ __ Agrees to come directly to the Health office if having the following symptoms after using medication:

____

The student does/does not demonstrate the specified responsibilities.
The student may carry the medication unless and until he/she fails to follow the above agreement.
Comments and added responsibilities:

____

____

__________________________________ __________________________________
(Student/date) (School Nurse/date)

I request that my child be allowed to carry his/her medication and be responsible for its proper storage and use. I will support my child to follow the above agreement and if he/she does not, I will be contacted and we develop a new plan.

__________________________________ __________________________________
(Parent/guardian/date) (Parent daytime telephone numbers)