Hopkins School District #270
Health Services

Self Carried / Self Administered Medication Agreement & Evaluation Form

Student _____ Grade/Program_____

Physician/Licensed Prescriber _____

Telephone _____

Medication _____ Dose _____ Time _____

Medication is permitted in accordance with district policy and procedure(s). In addition to the parent/legal guardian, the student's licensed prescriber/physician must authorize self-carried/administered medication. Student name must appear on the medication container, inhaler or injector.

Responsibilities for carrying medication

Yes No

The student's self-carry plan is in place and complete
The student can demonstrate correct use/administration
The student recognizes proper and prescribed timing for medication
The student agrees to not share medication with others
The student will keeps the medication in an agreed upon location(s)
(*please indicate location*) _____
The student will keep a second labeled container in the health office
(*optional, based on district policy and procedure(s)*)
The student agrees to come directly to the health office if having the following symptoms after using medication

_____

The student ___ is ___ is not able to demonstrate the specified responsibilities.
The student may carry the medication unless and until he/she fails to follow the above agreement.
Yes No
Comments and added responsibilities

_____
_____
_____

_____
(LSN/RN signature and date)

_____agrees with the above requirements: ___ Yes ___ No

_____
(Student signature and 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 a new plan will be developed.

_____ _____
(Parent/legal guardian signature and date) ***(Parent daytime telephone number(s)***