Student Agreement for Self-Carried Medication

Phone: 704-237-5333 Fax: 704-973-9594

Student: _____ DOB: _____Grade: _____ Academic Year:_____

Parent/Guardian: _____ Contact Number: _____

Licensed Health Care Provider: _____ Contact Number: _____

Medication: _____ Dose and Time: _____

Emergency medication is permitted in accordance with state laws. Both Student's health care provider and parent/guardian must complete the Prescription Medication Authorization form. Student's name must appear on the medication container. Only students with special medical needs, such as diabetes, asthma, or severe allergies or who are subject to anaphylactic reactions and may require emergency medications (i.e.; asthma inhaler, insulin, or epinephrine auto-injector) may possess and self-administer medications.

Health Care Provider: The student named above has a special medical condition that could require emergency medications. This student is capable of, has been instructed on the procedure for, and has demonstrated the skill to self-administer this medication as directed above. Please allow him/her to self-administer the medication during school hours and as otherwise indicated above and on the Prescription Medication Authorization Form.

[ ] This student will not require adult supervision while taking this medication.

Physician/Signature:_____Date: _____

Parent/Guardian: I give consent to Pine Lake Preparatory to allow my child to self-administer this medicine at school. I understand that my child and I assume responsibility for the proper use and safekeeping of this medicine. If the medication that is prescribed for my child is for the treatment of asthma or anaphylactic reactions, I agree to provide a supplementary supply of the medication that will be kept by the school in a location where my child has immediate access per G.S. 115-375.2. I absolve Pine Lake Preparatory, its agents and employees from any and all liability whatsoever that may result from my child possessing or taking this medicine at school.

Parent/Guardian Signature: _____ Date: _____

Student: I am capable of taking this medication as recommended and accept this responsibility. I agree to use my medication and/or equipment in a responsible manner, in accordance with my licensed health care provider's orders. I will keep it secure at all times and will not allow any other person to use my medication and/or equipment. I understand that I will be subject to discipline if I abuse the privilege of being allowed to self-medicate while at school or school-sponsored activities. I will notify an Academic Partner and/or the school nurse if I am having more difficulty than usual with my health condition.

Student signature: _____ Date: _____

School Nurse: I have reviewed this request and acknowledge that this student has demonstrated the skill level to use/self-administer this medication/equipment. I have informed this student that he/she must tell an appropriate staff member whenever he/she has used the medication at school.

- Medicine checked in
- Expiration Date _____

Nurse signature: _____ Date: _____