



## Student Contract for Self-Carried Emergency Medication(s) 2023-2024

STUDENT NAME: \_\_\_\_\_ GRADE: \_\_\_\_\_

PARENT/GUARDIAN: \_\_\_\_\_ PHONE: \_\_\_\_\_

HEALTHCARE PROVIDER: \_\_\_\_\_ PHONE: \_\_\_\_\_

MEDICATION: \_\_\_\_\_

EQUIPMENT: \_\_\_\_\_

In accordance with Cannon School's Health Room Policy, self-carried medication is permitted for **EMERGENCY MEDICATIONS** only. Both the student's Healthcare Provider and parent/guardian must complete and sign the "Authorization for Prescription Medication Administration" form. Prescription medication must be provided in the pharmacy labeled container with the student's name, prescriber's name, name of medication, dosage and directions for administration.

### Student Responsibilities

1. I will keep my medication/equipment with me at all times in \_\_\_\_\_.
2. I agree to use my equipment and take my medication in a responsible manner, in accordance with my Healthcare Provider's instructions/orders.
3. I will notify my teacher, school nurse or office personnel if I am having more difficulty than usual with my health condition so that my parents can be notified and emergency assistance can be obtained if necessary.
4. I will not allow any other person to take my medication or use my equipment.
5. I understand that the school undertakes no responsibility for the medication /equipment that I keep with me. Cannon School Board of Trustee's, their agents, and employees shall not be liable for any accident or injury that may result from or related to self-administration of this medication/equipment.
6. The condition and use of the medication/equipment is my responsibility.
7. It is the responsibility of my parent/guardian to notify the school of any changes in my health status or in the use of the medication or equipment listed above.

**Student's signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Parent's signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

The above named student may keep the medication or equipment with him/her at all times. He/she has been instructed in the purpose, administration, and side-effects of the medication/equipment. This student shows capability to carry and self-administer the above medication.

**Healthcare Provider's signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Cannon School accepts the parent request and Healthcare Provider's statement. Cannon School will permit and assist the student to be responsible, but reserve the right to withdraw the privilege if the student shows signs of irresponsible behavior or there is a safety risk. Cannon School will contact the parent as soon as possible in this event.

**School Nurse's signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_