Contract for Self-Carried Medication

Student: _____ Grade: _____

Physician: _____Telephone:_____

Medication: _____ Dose: _____Time: _____

Medication is permitted in accord with HMRSD policy (H8010 - Administering Medicines 6.15.17). Student's physician must authorize self-carried/administered medication. Student's name must appear on the (inhaler/container).

Responsibilities for Carrying Medication

Observed
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
____ ____ Agrees to come directly to the Health Office if having the following symptoms after using medication:
____ ____ Keeps a second labeled container in the Health Office.

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 s/he does not, I will be contacted and we will develop a new plan.

_____ _____
(Parent/guardian and date) (Parent daytime telephone numbers)