201 Forest Street, Marlborough, MA 01752
OFFICE OF SCHOOL NURSE Phone 508 597-2475/2473 – Medical FAX 508 485-0825

Contract for Permission to Carry and Self Administer Seizure Medications 23-24

Name of Student: _____ Grade: 6 7 8 9 10 11 12

To be completed by the Parent/Guardian:

Qualified students will be allowed to carry their Seizure medications with them in school and on field trips at the discretion of the school nurse. Parents only need to sign the agreement. The school nurse and your child complete the rest of the form. Please contact the school Nurse if there are any changes to your child's medication and/or treatment plan during the school year**.**

I request that my child be permitted to carry on his/her person the medication that has been prescribed. My child has been instructed in and understands the purpose, appropriate method, frequency, and use of his/her medication. My child understands that he/she is responsible and accountable for carrying and using his/her medication. My child understands that he/she will be responsible for carrying and self-administering this medication under the contract agreement level checked below. It is understood that if there is irresponsible behavior or safety risk, the privilege of carrying his/her medication will be rescinded. I will support my child in following the agreement

Parent/Guardian Signature: _____ _ Date:_____

CONTRACT AGREEMENT: Check One

☐ **COP (Carries on person at all times)**
☐ **FTAS (Field Trips/Sports/ After School Activities)**
☐ **DNC (Does Not Carry. Chaperone/coach/club leader carries and student to be with them for duration of event)**
☐ **Other to be determined by Sch. Nurse: _____**

To be completed by School Nurse and Student		
Physicians order for this medication is on file in the Health Office	Yes ☐	No ☐
Student is consistently able to name and identify the correct medication, knows the correct dosage, time it needs to be administrated and purpose of the medication	Yes ☐	No ☐
Student can explain the proper storage requirements of his/her medication and agrees to follow those medication storage requirements	Yes ☐	No ☐
Student demonstrates safe and correct use/administration of medication and agrees to carry only the amount of medications required.	Yes ☐	No ☐
Student agrees to be responsible to provide and carry his/her own medication on field trips/after school activities/sports. If student forgets to bring his/her medication, & there is no backup in H.O. then 911 will be called if medication is required	Yes ☐	No ☐
Student agrees that after administering this medication he/she will immediately inform a faculty member to call 911.	Yes ☐	No ☐
Student realizes his/her responsibility in carrying his/her own medication(s) and agrees ***NEVER*** share the medication(s) with others.	Yes ☐	No ☐
Student agrees to maintain a backup medication in the health Office	Yes ☐	No ☐
The student understands that the privilege of carrying and administering his/her own medication(s) will be rescinded if he/she does not follow the above agreement.	Yes ☐	No ☐

Expiration date on Medication in HO is _____ Expiration date on Medication student is carrying is _____

Amount of medication student can carry _____

I give permission to notify staff of my plan of self-administration. I understand that if I do not follow the plan of self-administration according to guidelines stated above, or misuse my medication in any way, this agreement will be immediately terminated. Written notification of termination will be sent by nurse to my parents and teachers within 24 hours.

Student Signature: Date:

This student ☐ does ☐ does not demonstrate the required responsibilities
This student ☐ may ☐ cannot carry/self-administer the medication.

Nurse Signature: Date: