



SIGNATURE PREPARATORY

Student Agreement for Self-Carried Medication

Student: _____ **Grade:** _____

Parent/Guardian Printed Name: _____ **Phone Number:** _____

Emergency Contact Name: _____ **Phone Number:** _____

Health Care Provider: _____ **Phone Number:** _____

Type of Medication: Asthma Inhaler Epinephrine Auto-Injector Diabetic Medication/Supplies

Medication: _____ **Dose and Time:** _____

Purpose: _____

Potential Side Effects: _____

Medication is permitted in accordance with state laws and district policy, both student's health care provider and parent guardian must complete Medication Authorizations Form. Student name must appear on medications and devices.

Student Responsibilities

- o I will keep my asthma inhaler, Epinephrine Auto Injector, or diabetes medication/supplies with me at school.*
- o I agree to use my asthma inhaler, Epinephrine Auto-Injector, or diabetes medication/supplies in a responsible manner, in accordance with my licensed health care providers orders.*
- o I will notify the school staff (i.e., teacher, nurse) if I am having more difficulty than usual with my health condition.*
- o I will not allow any other person to use my medication or equipment.*
- o I will discard any medical waste potentially contaminated with biological hazards under supervision of a health office designee.*

Student Signature: _____ **Date:** _____

___ Emergency Action Plan complete and on file at school

___ Demonstrates correct use/administration

___ Verbalizes proper and prescribed timing for medication

___ Can describe own health condition well

___ Will not share medication or equipment with others

As the parent/guardian of the above-named student, I have read the protocols for containing blood-borne pathogens and the handling and disposal of needles, medical devices and other medical waste. I further acknowledge that the above-named student will be held accountable for following the set protocols. Their authorization to self-administer medication may be revoked if the student fails to comply with the protocols for containing blood-borne pathogens and safe-handling/disposal of needles, medical devices, and other medical waste.

As the parent/guardian of the above-named student, I grant permission for the student to carry and self-administer the above-named medication while on campus or participating in an activity sponsored by the school. I acknowledge that Signature Preparatory, its employees, or agents shall incur no liability as a result of any injury/death arising from the self-administration, failure to administrate when needed, or misuse of the above-named medication by the student. I agree to hold harmless the school and its employees or agents against any claims arising out of such self-administration.

Parent/Guardian Signature: _____ **Date:** _____

School Nurse/Principal: _____ **Date:** _____

Physician Signature: _____ **Date:** _____