



Parent/Student Contract to Self-Carry and Self-Administer Medication

Student _____ DOB _____ Grade _____ School _____
Physician _____ Office _____ Fax _____
Medication _____ Dose _____ Time _____ Frequency _____
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Medication is permitted in accordance with SJPSB medication policy. The student's parent/legal guardian and physician must authorize self-carry and self-administration of medication before medication can be carried and self-administered.

Guidelines to self-carry Medication:

YES	NO	
_____	_____	I understand the proper use and administration of my medication.
_____	_____	I understand that I am not to share my medication with others.
_____	_____	I will keep my medication and all supplies in the agreed location or carried on myself at all times.
_____	_____	I agree to come directly to the office with a buddy or escort if I am not feeling well or having the following symptoms: _____ _____
_____	_____	I understand that my self-carry and self-administration privileges will be taken away if I fail to follow these guidelines.
_____	_____	I understand that I am to carry my medication on ALL Field trips/school related activities (during school hours, beyond school hours and on overnight field trips)

I (parent/legal guardian) request that my child, named above, be permitted to self-carry and self-administer the above ordered medication(s). I take responsibility for this permission. I understand that medication(s) must be in its original pharmacy labeled container with name of the student, medication, prescribing physician, date prescription filled, medication strength, dose, and directions for use.

By signing this contract, I (parent/legal guardian) acknowledge that I understand the above guidelines and that SJPSB shall incur no liability and that I shall indemnify and hold harmless SJPSB and its employees against any claims that may arise relating to the self-administration of medication(s) by the student.

Student Signature

Date

Parent/Guardian Signature

Date

_____ The above named student **MAY** self-carry and self-administer his/her medication.
****Privileges will be taken away if the above conditions are not followed.****

School RN Signature

Date