

Self Carry Contract for: _____(medication name)

School: _____Grade: _____School Year: _____

STUDENT: _____ **DOB:** _____

- I plan to keep my medication with me rather than in the school health office.
- I agree to use my medication in a responsible manner, in accordance with my physician's orders.
- I will notify the school health office if I am having more difficulty than usual with illness.
- I will not allow any other person to use my medication.

Student's Signature _____ **Date** _____

PARENT / GUARDIAN: _____

This contract is in effect for the current school year unless revoked by the physician or the student fails to meet the above safety contingencies.

- I agree to see that my child carries his/her medication as prescribed, in its original container, and the date is current.
- It has been recommended to me that a back-up medication be provided to the Health Office for emergencies.
- I will review the status of the student's illness with the student on a regular basis as agreed in the health care plan.
- I will provide the school a Health Care Provider signed medication authorization for this medication. (If possible)

Parent/Guardian Signature _____ **Date** _____

SCHOOL RN: _____

The above student has demonstrated correct use of medication, an understanding of the physician order for time and dosages, and an understanding of the concept of medical necessity. School staff that have the need to know about the student's condition and the need to carry medication have been notified. I will review the medication authorization, if provided by the parent, and signed by the health care provider.

Nurse Consultant's Signature _____ **Date** _____

Administrator Signature _____ **Date** _____