School District of Holmen Medication Self-Carry Agreement

Student Name:_____ **Birthdate:**_____ **Grade:**_____

Part 1: Check medication(s) that apply

- ❑ Tylenol/Acetaminophen:
  - ❑ Students age 11: 160 - 500 mg every 4 to 6 hours as needed for pain/fever
  - ❑ Students ages 12 and above: 325 - 1,000 mg every 4 to 6 hours as needed for pain/fever
- ❑ Ibuprofen/Motrin/Advil: 200-400 mg every 4 to 6 hours as needed for pain
- ❑ Antacid: 1-2 chews every 2 hours as needed for indigestion
- ❑ Lactase enzyme/Lactaid: 3,000 to 9,000 units as needed before dairy consumption
- ❑ Cough Drop: 1 drop every hour as needed for cough and/or sore throat
- ❑ Zyrtec: 10 mg once daily as needed for allergy symptoms
- ❑ Benadryl: 25-50 mg every 4 hours as needed for allergy symptoms (maximum 25 mg per dose for age 11 years)
- ❑ Midol: 1-2 tablets every 6 hours as needed for menstrual cramps (not recommended for age 11)
- ❑ Other medication name, dose, frequency, and for what use, list all:

_____

For prescription medications, complete the School Medication and Procedure Form and have the medical provider write the student has permission to self-carry the medication on the form. Medication must be carried in its original packaging. **Controlled substances cannot be self-carried and must be stored in the health office.**

Part 2: Check all safety agreement boxes and signatures

To self-carry medication at school:

- ❑ Self-Carry Agreement Form completed and in the school's office.
- ❑ Medication label and Self-Carry Agreement Form must match
- ❑ Medication must be carried in the original packaging, and administration instructions must be legible
- ❑ Student's name must be on the medication packaging
- ❑ Student cannot share medication with anyone

I give consent for my student to self-carry and administer the medication listed above. I have reviewed and agree to follow the district's self-carry guidelines. I understand that if my student does not follow the self-carry guidelines they will lose the privilege of being able to self-carry and administer medication at school.

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

I agree to take personal responsibility for the medication listed above. I have reviewed and agree to follow the district's self-carry guidelines. I understand that if I do not follow the self-carry guidelines I will lose the privilege of being able to self-carry and administer medication at school.

Student Signature:_____ **Date:**_____

Part 3: School Nurse and Principal must approve and sign form to self-carry medication(s)

School Nurse Signature: _____ **Date:** _____

Principal Signature: _____ **Date:** _____