

Medication Self Carry Contract

School: _____

School Year: _____

Student:	Birthdate:	Grade:
<ul style="list-style-type: none"><input type="radio"/> I will keep my medication secure.<input type="radio"/> I will follow my health care provider's instructions.<input type="radio"/> I will not share my medication with any other person.<input type="radio"/> If I don't use my medication safely, I may lose this privilege.		
Student's signature _____		Date _____

Parent/Guardian:	
<p>This contract is in effect for the current school year unless revoked by the health care provider or student fails to meet the above contingencies.</p> <ul style="list-style-type: none"><input type="radio"/> I agree to make sure my child carries the correct medication, that the medication is not expired, and the medication has my child's name on it.<input type="radio"/> I understand that school staff may review this contract with me if my child doesn't follow health care provider orders or doesn't follow agreement.<input type="radio"/> I will review the status of the student's health concern on a regular basis.<input type="radio"/> I will provide a medication authorization to school, signed by me and a health care provider.	
Parent's Signature _____	Date _____

School Nurse Consultant:	
<ul style="list-style-type: none"><input type="radio"/> I have notified the appropriate staff that need to know of the student's health condition and have advised them of the student's authorization to carry and self-administer medication.<input type="radio"/> I have verified that all appropriate paperwork has been completed.	
School Nurse Consultant Signature _____	Date _____

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