Medication Self Carry Contract

School: _____ School Year: _____

Student:	Birthdate:	Grade:

- I will keep my medication secure.
- I will follow my health care provider's instructions.
- I will not share my medication with any other person.
- If I don't use my medication safely, I may lose this privilege.

Student's signature_____ Date_____

Parent/Guardian:

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.

- 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.
- 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.
- I will review the status of the student's health concern on a regular basis.
- I will provide a medication authorization to school, signed by me and a health care provider.

Parent's Signature_____ Date_____

School Nurse Consultant:

- 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.
- I have verified that all appropriate paperwork has been completed.

School Nurse Consultant Signature_____ Date_____