Contract for Self-Carried Medication

Student: ______________________________ Grade: ________________________________

Provider: _____________________________ Medication: ______________________________

The student's name must be on the medication (inhaler, container, etc.)

Responsibilities of Carrying Medication:

Observed:
Yes No

___ ___ Medical Condition Action Plan complete

___ ___ Demonstrates correct use/administration

___ ___ Recognizes proper and prescribed timing for medication

___ ___ Does not share medication with others

___ ___ Keeps medication in agreed location

___ ___ Agrees to come directly to Nurse's Office if having the following symptoms after using Medication: ____

___ ___ Keeps a second labeled container in the Nurse's Office

The student demonstrates the specified responsibilities. The student may carry the medication unless and until he/she fails to follow the above agreement.

Comments and added responsibilities:

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____ ____________________________________
(Student/date) (School Nurse/date)

I request that my child be allowed to carry his/her medication and be responsible for its proper storage and use. I will support my child to follow the above agreement and if he/she does not, I will be contacted and we will develop a new plan.

____ ____________________________________
(Parent or Guardian/date) (Telephone number)