Contract to Self Carry
Emergency Medications At School

Student Name:	
Medication to be Self Carried:	

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

Student

☐ I plan to keep my medication with me at school rather than in the school health office.
☐ I agree to use my medication in a responsible manner, and in accordance with my physician's orders.
☐ I will notify the school health office when I use my medication.
☐ I will not allow any other person to use my medication.

Student Signature:	**Date:**

Parent/Guardian

☐ I agree to see that my child carries their medication as prescribed, that the medication is in proper condition and not expired.
☐ I will provide back-up medication to the School Health Office for emergencies.
☐ I will review the status of my child's condition with him/her on a regular basis.
☐ I will insure that my child brings their medication to school every day.

Parent/Guardian Signature:	**Date:**

Health Care Provider

☐ The above student has demonstrated correct use of their medication and an understanding of the physician's orders regarding their condition.
☐ School staff that have the need to know about the student's condition and plan to self carry medication have been notified.

Health Care Provider Signature:	**Date:**
District Nurse Signature:	**Date:**
School Health Service Provider Signature:	**Date:**

Revised 9/2018