

DIOCESE OF CHARLOTTE

**SELF-MEDICATING STUDENT / PARENT / PHYSICIAN AGREEMENT**

**FOR INSULIN, EPI PENS AND ASTHMA MEDICATION ONLY**

**PHYSICIAN AGREEMENT:**

I have provided education to \_\_\_\_\_  
(Student's Name)

and given the authorization for self-administration of \_\_\_\_\_  
(Medication)

during school hours and activities.

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

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**PARENT AGREEMENT:**

I, \_\_\_\_\_, agree that my child, \_\_\_\_\_  
(Parent/Guardian's Name) (Student's Name)

is knowledgeable of his/her treatment and is capable of self-administering the medication.

Parent / Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

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**STUDENT AGREEMENT:**

I agree and feel competent to take my own insulin, Epi Pen and/or asthma medication as prescribed. I will not at any time share my medication with another student and I will keep it secure from other students.

If I have any problems self-administering my medication or any health problems arise, I will seek assistance from school personnel so not to jeopardize the health or the safety of myself or my fellow students.

Student's Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_ Birth Date \_\_\_\_\_