CONTRACT FOR SELF-CARRIED MEDICATION

Student: ___________________________ Grade: __________

Physician: ___________________________ Telephone: ___________________________

Medication: ___________________________ Dose: __________ Time: __________

Medication is permitted in accordance with district policy. Student’s physician must authorize self-carried/administered medication. Student name must appear on the medication container or inhaler.

Responsibilities for carrying medication:
Yes  No
— ___ Health care action plan complete
— ___ Demonstrated correct use/administration
— ___ Recognizes proper and prescribed timing for medication
— ___ Does not share medication with others
— ___ Keeps medication in agreed location
— ___ Keeps second labeled container in the Health office
— ___ Agrees to come directly to the Health office if having the following symptoms after using medication:

______________________________________________

The student does/does not demonstrate the specified responsibilities.
The student may carry the medication unless and until he/she fails to follow the above agreement.
Comments and added responsibilities:

______________________________________________

______________________________________________

(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 develop a new plan.

______________________________________________

(Parent/guardian/date) ___________________________ (Parent daytime telephone numbers) ___________________________

Albemarle County Public Schools