



CONTRACT FOR SELF-CARRIED MEDICATIONS and/or SELF-ADMINISTERED TREATMENTS

Student's Name: _____ ID _____ School: _____ Grade: _____

Physician's Name: _____ Telephone: _____

Name of Medication/Treatment: _____

Dosage (Medication): _____ Frequency: _____

Equipment/Supplies Needed: _____

Self-carried medication and self-administered treatments are permitted in accordance with school district policy. The student's physician must authorize self-carried medication or self-administered treatments and parent/guardian(s) must give permission for the student to use medication or perform treatments while in school. An Individualized Health Care Plan must be completed for each student to self-carry or self-treat.

The student must agree to and/or demonstrate all of the following items before they may self-administer or self-treat at school. The school nurse will arrange periodic meetings to evaluate the student's continued knowledge and skills related to self-administration/self-treatment procedures. Responsibilities for the student to self-carry/self-treat include the following items:

Competencies	Date Reviewed	Date Reviewed	Nurse Signature
Recognizes prescribed purpose of medication or treatments (proper dosage of medication)			
Demonstrates competency in self administration or self treatments			
Agrees to keep medication or treatment supplies in designated locations(s)			
Agrees not to share medications or treatments supplies or materials with others			
Consents to report to the health room if symptoms do not resolve			
Proper disposal of medications or supplies in school and at school-sponsored activities			

Comments and/or added responsibilities: _____

Students may only self-carry medication or perform self-treatments as long as they follow the procedures as demonstrated. It is also understood that if there is any irresponsible behavior or safety risk, this *privilege* will be rescinded.

I agree to follow the above guidelines and procedures for self-administering medications or performing self-treatments at school and during school-sponsored activities.

 Student's Signature Date

I request that my child be allowed to self-carry his/her medication or perform self-treatments and be responsible for proper storage and use of equipment and supplies.

 Parent/Guardian's Signature Date Parent daytime telephone numbers

 School Nurse's Signature Date