CURRITUCK COUNTY SCHOOLS

Permission and Contract for Self-Carried and Self-Administered Medication

STUDENT'S NAME:_____ DOB:_____

SCHOOL:_____TEACHER/GRADE:_____

PARENT SIGNATURE: _____PHONE:_____

PHYSICIAN'S SIGNATURE: _____PHONE:_____

MEDICATION::_____ DOSAGE/TIME: _____

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Self-Medication Contract

Self medication is permitted in accordance with Policy 6125. Both the student's health care provider and parent/guardian must complete the Authorization for Medication Form in addition to this form when a student is deemed responsible to carry and self-medicate. The student's name must appear on the inhaler/container or Epi-Pen.

Student Responsibilities

I plan to keep my inhaler, equipment, Epi-Pen, or medication with me at school, in transit, or at a school sponsored event rather than storing it in the nurse's clinic. In doing so, I agree to the following conditions:

• I agree to demonstrate to the school nurse, or the nurse's designee, the skill level necessary to use the medication and any device that is necessary to administer the medication for which I have authorization to use.

• I agree to use my inhaler, equipment, Epi-Pen, or medication in a responsible manner, in accordance with my licensed health care provider's orders.

• I agree to notify the school nurse or main office if I experience more difficulty than usual with my health condition.

• I will not allow any other person to use my inhaler, equipment, Epi-Pen, or medication.

_____ _____

(Student signature) (date)