



****This is a 2 page document. Both pages must be completed to be legal****

Contract to Self-Carry Medications at School, School Sponsored Events, Field Trips

Student's Name _____

This section must be completed by a PHYSICIAN with PRESCRIBING AUTHORITY for medication that will possibly need to be self-carried by your student at any time at school or at a school sponsored event. Medications that are permitted to be self-carried at the Elementary School level include Inhalers, EPI PENS, and Insulin.

Medication: _____

Dosage: _____ Route: _____
(PLEASE BE SPECIFIC)

Time(s) of day medication is to be taken: _____
(PLEASE BE SPECIFIC)

Anticipated length of time needed: _____

Purpose of Medication: _____

Special Instructions: _____

Possible Side Effects: _____

Physician Certifies that:

1. This student has demonstrated and understands the proper use of this medication.
2. This student is approved to self-carry the medication listed above on this form.
3. I have written a prescription for this student for this specific medication.
4. I have completed and signed a "Care Plan" for this student if applicable.

Phone Number of Prescribing Healthcare Provider: _____

Print Prescribing Healthcare Provider's Name: _____

Signature of Health Care provider with Prescriptive Authority

Date

Student agrees to the following:

1. I plan to keep my medication with me at school rather than in the school health office.
2. I agree to use my medication in a responsible manner and in accordance with my physician's orders.
3. I will notify a school staff member if I have used an EPIPEN and/or Inhaler.
4. I will notify a school staff member if I am experiencing symptoms of my condition and may need assistance.
5. I will not allow any other person to use my medication.

Student Signature: _____ **Date:** _____

****This contract is in effect unless revoked by our staff health consultant or the student's physician or the student fails to meet the safety requirements to self-carry a medication. ****

Parent/Guardian agrees to the following:

1. I hereby give my permission for my student to self-carry and be solely responsible for self-administering the medication listed on this form.
2. I agree to ensure that my student self-carries his/her medication in **its' original labeled packaging. I will ensure that his/her medication is not expired.**
3. I agree to provide a backup medication to be kept at the school for emergencies if my student has a life-threatening allergy that could require an EPIPen or if my student has Asthma that could require the use of an inhaler.
4. I will review the status of my child's condition with him/her on a regular basis.
5. I will ensure that my child brings his/her medication to school every day.
6. I release DMS from any responsibility for side effects or other medical consequences that occur as a result of my student taking this medication.

Parent/Guardian Signature: _____ **Date:** _____

Parent/Guardian Printed Name: _____

Phone Number: _____