School Year: _____ Medication Expiration Date: _____

STUDENT SELF-CARRY MEDICATION AGREEMENT
(EMERGENCY MEDICATIONS: INHALERS, EPI-PENS)

Student's Name: _____ Grade: ____ DOB: _____ School: _____
Medication: _____ Dosage: _____ Route: _____
Reason medication is prescribed: _____

Licensed Health Care Provider Signature

This student is capable of and has been instructed on how to self-carry and, if applicable, administer this medication as directed. Please allow them to self-carry this medication during school hours. In the event of an emergency, this student may need assistance from a school staff member in the administration of this medication.

_____ _____ Licensed Health
Care Provider Signature Date

Parent/Guardian Permission

I, _____ agree that my student_____
____ can self-carry emergency medication but needs assistance to administer emergency medication
____ can self-carry and self-administer emergency medication

As the parent/guardian of this student, I assume the responsibility for any adverse reactions this medication may cause for my student. I understand that the school and its employees are not liable for any injury arising from my student's possession and/or self-administration of this medication. I understand that I should provide the school with backup emergency medication to be kept at school in a location that is accessible in the event of an emergency.
I give permission for the school and my student's healthcare provider to communicate and share any needed forms by fax. I understand the school cannot guarantee the confidentiality of the fax machine.

_____ _____
Signature of Parent/Guardian Date

_____
Parent/Guardian Telephone Number

Student Agreement (to be completed with School Nurse)

I am capable of carrying this medication as recommended and accept this responsibility. I will keep it secure at all times and will not share it with others. I will inform a school staff member when medication is used. If I am unable to self-administer my emergency medication, I will notify a school staff member. I understand that if I do not follow the above guidelines, I may lose my ability to self-carry this medication.

_____ _____
Signature of Student Date

_____ _____
Signature of School Health Nurse Date

Revised 7/7/22