STUDENT SELF-CARRY / SELF ADMINISTRATION PARENT CONSENT, STUDENT CONTRACT & EVALUATION FORM
Grades 9-12

Student_____ Grade_____

Medication_____ Dose_____ Time_____

Medication is permitted in accordance with the school policy and procedure(s). I request that my student carry his/her medication and be responsible for proper storage and use. I will support my child to follow the agreement and take full responsibility of their use of self administered medications.

Parent/Guardian _____

Date_____ Daytime Phone _____

STUDENT CONTRACT

- I can demonstrate correct use/administration
- I know proper and prescribed timing of administration
- I agree not to share medication with others
- I will keep medication in following location _____
- I will keep the medication in its original container

Student Signature _____ Date_____

_____ has agreed with the above requirements and may carry the medication unless he/she fails to follow the agreement.

LSN/RN Signature_____ Date_____