ACADEMY DISTRICT 20

Student Contract for Medication Self-Carry

(no controlled substances)

Student Name:_____ DOB:_____
School:_____Teacher / Grade:_____
Parent / Guardian: _____Daytime Phone:_____

STUDENT

☐ I plan to keep my _____ with me at school rather than in the school health office.

☐ I agree to use my _____ in a responsible manner, in accordance with my physician's orders.

☐ I will notify the school health office if I am having more difficulty than usual with my _____.

☐ I will not allow any other person to use my _____.

Student's Signature: _____Date: _____

PARENT/GUARDIAN

This contract is in effect for the current school year unless revoked by the physician or the student fails to meet the above safety contingencies.

☐ I agree to see that my child carries his/her medication as prescribed, and the date is current.

☐ I will review the status of the student's _____with the student on a regular basis as agreed in the treatment plan.

Parent's Signature: _____Date: _____

SCHOOL NURSE

☐ The above student has demonstrated correct technique for_____ use, and understanding of the physician order for time and dosages.

☐ School staff that have the need to know about the student's condition and the need to carry medication have been notified.

Registered Nurse's Signature: _____Date: _____