DODGELAND SCHOOL DISTRICT
CONTRACT FOR SELF-CARRIED MEDICATION

Student ______________________________ Grade __________

Medication ______________________________ Dose __________ Time __________

Medication is permitted in accordance with District policy. The student's physician must authorize self-carried/administered medication. **Includes only emergency medications such as epi-pen, inhaler. This does not include over the counter medications.** The student's name must appear on the medication container.

Responsibilities for Carrying Medication:

Observed:

☐ Yes ☐ No Health care plan complete

☐ Yes ☐ No Demonstrates correct use/administration

☐ Yes ☐ No Recognizes proper and prescribed timing for medication

☐ Yes ☐ No Does not share medication with others

☐ Yes ☐ No Keeps medication in agreed location

☐ Yes ☐ No Agrees to come directly to the school nurse's office if having the following symptoms after using the medication:

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☐ Yes ☐ No Keeps second labeled container in the nurse's office

The student does/does not demonstrate the specified responsibilities. The student may/may not carry the medication unless and until he/she fails to follow the above agreement.

Physician Signature ______________________________ Date __________

Student Signature ______________________________ Date __________

I request that my child be allowed to carry his/her medication and be responsible for its proper storage and use. I will support my child to follow the above agreement and if he/she does not, I will be contacted and we will develop a new plan.

Parent/Guardian Signature ______________________________

Date __________ Phone Number ______________________________

Revised May, 2016