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**Parent/Student Contract to Self-Carry and Self-Administer Medication**

Student\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_Grade\_\_\_\_\_\_\_School\_\_\_\_\_\_\_

Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Office\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dose\_\_\_\_\_\_\_\_\_\_\_\_Time\_\_\_\_\_\_\_\_\_\_\_\_\_Frequency\_\_\_\_\_\_\_\_\_

Medication\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dose\_\_\_\_\_\_\_\_\_\_\_\_Time\_\_\_\_\_\_\_\_\_\_\_\_\_Frequency\_\_\_\_\_\_\_\_\_

Medication\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dose\_\_\_\_\_\_\_\_\_\_\_\_Time\_\_\_\_\_\_\_\_\_\_\_\_\_Frequency\_\_\_\_\_\_\_\_\_

Medication\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dose\_\_\_\_\_\_\_\_\_\_\_\_Time\_\_\_\_\_\_\_\_\_\_\_\_\_Frequency\_\_\_\_\_\_\_\_\_

**Medication is permitted in accordance with SJPSB medication policy. The student’s parent/legal guardian and physician must authorize self-carry and self-administration of medication before medication can be carried and self-administered.**

**Guidelines to self-carry Medication:**

 YES NO

\_\_\_\_\_\_ \_\_\_\_\_\_ I understand the proper use and administration of my medication.

\_\_\_\_\_\_ \_\_\_\_\_\_ I understand that I am not to share my medication with others.

\_\_\_\_\_\_ \_\_\_\_\_\_ I will keep my medication and all supplies in the agreed location or carried on myself at all times.

\_\_\_\_\_\_ \_\_\_\_\_\_ I agree to come directly to the office with a buddy or escort if I am not

 feeling well or having the following symptoms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_ \_\_\_\_\_\_ I understand that my self-carry and self-administration privileges will be taken

 away if I fail to follow these guidelines.

\_\_\_\_\_\_ \_\_\_\_\_\_ I understand that I am to carry my medication on ALL Field trips/school related activities (during school hours, beyond school hours and on overnight field trips)

**I (parent/legal guardian) request that my child, named above, be permitted to self-carry and self-administer the above ordered medication(s). I take responsibility for this permission. I understand that medication(s) must be in its original pharmacy labeled container with name of the student, medication, prescribing physician, date prescription filled, medication strength, dose, and directions for use.**

**By signing this contract, I (parent/legal guardian) acknowledge that I understand the above guidelines and that SJSB shall incur no liability and that I shall indemnify and hold harmless SJPSB and its employees against any claims that may arise relating to the self-administration of medication(s) by the student.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Student Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Parent/Guardian Signature Date

\_\_\_\_\_\_ The above named student ***MAY*** self-carry and self-administer his/her medication**.*\*\*Privileges will be taken away if the above conditions are not followed.\*\****

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 School RN Signature Date

Revised: 5/2016