

Self-Administration of Medication

Student Agreement

I agree to:

- Follow my prescribing health professionals' medication orders.
- Use correct medication administration technique.
- Not allow anyone else to use my medication
- Keep a supply of my medication with me in school and on field trips.
- Notify the school nurse or health office personnel if the following occurs:
 - My symptoms continue or get worse after taking the medication
 - My symptoms reoccur within 2-3 hours after taking the medication
 - I suspect that I am experiencing side effects from my medication
 - Other_____

I understand that permission for self-administration of medication may be suspended if I am unable to maintain the procedural safeguards established above.

signature of student

date

I have read the above student agreement.

signature of parent/guardian

date

(see attached Medication Authorization Form)