School District of Holmen

Medication Self-Carry Agreement for High School Students

Student Name: _____ Birthdate: _____ Grade: _____

Part 1: TO BE COMPLETED BY PARENT/GUARDIAN AND STUDENT

USE A SEPARATE SHEET FOR EACH MEDICATION

Medication:_____ Dosage:_____

Time(s) to be taken at school:_____

If PRN, specify when indicated (signs/symptoms): _____

Frequency of administration: _____

Part 2: TO BE COMPLETED BY PARENT/GUARDIAN AND STUDENT

To self-carry medication at school:

- ☐ Authorization to Administer Prescription Medication form and Self-Carry Agreement must be filed in the school's office
- ☐ Medication label and Authorization to Administer must match
- ☐ Medication must be carried in the original packaging, and administration instructions must be legible
- ☐ Student's name must be on the medication packaging
- ☐ Student cannot share medication with anyone

I give consent for my student to self-carry and administer the medication listed above. I have reviewed the district's medication policy and agree to follow the self-carry guidelines. I understand that if my student does not follow the medication policy they will lose the privilege of being able to self-carry and administer medication at school.

Parent/Guardian Signature: _____ Date: _____

I agree to take personal responsibility for the medication listed above. I have reviewed the district's medication policy and agree to follow the self-carry guidelines. I understand that if I do not follow the medication policy I will lose the privilege of being able to self-carry and administer medication at school.

Student Signature: _____ Date: _____

Part 3: MUST BE COMPLETED IF PRESCRIPTION MEDICATION

School Nurse Review:

- ☐ Appropriate forms are filed in school office
- ☐ Medication is packaged appropriately according to district policy
- ☐ Student understands the district medication policy on self-carrying medications and consequences if not followed
- ☐ Student knows the medication name, how medication works, when to take the medication, and when to ask an adult for help

School Nurse signature: _____ Date: _____

- ☐ Infinite Campus health alert has been entered for teachers to view.