

DODGELAND SCHOOL DISTRICT
CONTRACT FOR SELF-CARRIED PRESCRIPTION MEDICATION
Fax # 920-386-4498

Student _____ Grade _____

Medication _____ Dose _____ Time _____

The student's physician must authorize self-carried/ administered prescription medication.

Medication is permitted in accordance with District policies.

Per Board Policy #5330 – Administration of Medication/Emergency Care, only medication in its original container; labeled with the date; the student's name; and the exact dosage will be administered.

Includes only emergency prescription medications, such as epi-pen or inhaler.
This does NOT include over-the-counter medications.

Responsibilities for Carrying Medication:

Observed:

- | | | |
|------------------------------|-----------------------------|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Health care plan complete |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Demonstrates correct use/administration |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Recognizes proper and prescribed timing for medication |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Does not share medication with others |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Keeps medication in agreed location |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Agrees to come directly to the school nurse's office if having the following symptoms after using the medication: |

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

The student demonstrates the specified responsibilities listed above and may carry the medication, unless and until the student fails to follow the above agreement.

Physician Signature _____ Date _____

Student Signature _____ Date _____

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

Parent/Guardian Signature _____

Date _____ Phone Number _____