Student's Name:	Date of Birth:

Self-Administration of Medication
Student Agreement

I agree to:

- Follow my health care provider's medication order.
- 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 of health office personnel if the following occurs:
  - My symptoms continue or get worse after taking my medication
  - My symptoms reoccur within 2-3 hours after taking my 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:** _____

The student has demonstrated knowledge about proper use of _____.

Signature of School Nurse: _____ **Date:** _____

I give permission for my child to self-administer medication at school as prescribed by my child's health care provider. I have read and understand the above agreement.

Signature of Parent/Guardian: _____ **Date:** _____

See attached form: Request to Administer Medication at School