

Student Agreement For Self-Carried Medication

The Learning Center! Charter School

Student: _____ Grade: _____

Parent: _____ Telephone Number: _____

Licensed Health Care Provider: _____ Telephone Number: _____

Medication: _____ Dose and Time: _____

Medication is permitted in accord with state laws and district policy. Both student's health care provider and parent/guardian must complete "Request for Medication Administration in School" (RMAS) Form. Student's name must appear on inhaler/container.

STUDENT RESPONSIBILITIES

- I plan to keep my inhaler, equipment, and/or Epinephrine auto injector with me at school.
- I agree to use my inhaler, equipment, and/or Epinephrine auto injector in a responsible manner, in accordance with my licensed health care provider's orders.
- I will notify the school staff (i.e., teacher, nurse) if I am having more difficulty than usual with my health condition.
- I will not allow any other person to use my inhaler, equipment, and/or Epinephrine auto injector. If I use the medication in a manner other than as prescribed, the school may impose disciplinary action according to the school's disciplinary policy.

Student's signature: _____ Date: _____

Upon completion of this checklist, the student with written parental and physician consent, may self-medicate under the supervision of trained school personnel.

_____ Responds to his/her name and visually recognizes his/her written name.

_____ Identifies his/her medication.

_____ Demonstrates correct use/administration of medication.

_____ Recognizes proper and prescribed timing for medication.

_____ States reasons for taking medication and identifies signs and symptoms indicating use.

_____ Agrees to carry medication.

_____ Will not share medication or equipment with others.

_____ Keeps a second labeled container in health office or main office per G.S. 115C-375.2

_____ Demonstrates a cooperative attitude in all aspects of self-administration of medication.

_____ 'Request for Medication Administration in School' form completed.

Comments:

_____ Date: _____

Licensed Health Care Provider (MD, DO, APN, NP)

_____ Date: _____

Principal