TRINITY OAKS Christian Academy

Self-Carry and Self-Administration of Medications

Student Agreement

I agree to:

- Follow my licensed health care provider's medication administration instructions according to the current medication authorization and health care plan.
- Use the correct medication administration technique.
- Not allow anyone else to use my medication.
- Keep my pharmacy-labeled medications with me during regular school hours.
- Inform my parent or legal guardian when I am close to running out of medication or the medication is close to the expiration date on the label.
- Notify the office staff and my teacher if the following occur:
  - My symptoms continue or get worse after taking the medication.
  - My symptoms reoccur during the same school day.
  - I suspect that I am experiencing side effects from my medication.
  - Other _____
- I am knowledgeable about my prescribed medicine's proper use and the side effects.
- I understand that permission to self carry and self-administer my medication is designed to enhance my self-care skills as I move toward increased independence.
- I understand that permission for possession and self-administration of my medication will be re-evaluated if I am unable to abide by the listed criteria.

_____

Signature of Student Date

_____

Print Name of Student

I have read and concur with the above student agreement.

_____

Signature of Parent / Guardian Date

_____

Print name of Parent / Guardian

The student has demonstrated knowledge about and proper use of his/her emergency medications.

_____

Signature of School Administrator Date