Holly Area Schools

Contract for Self Administration/Possession of Emergency Medication

This form is valid for one calendar school year only

Student's Name: _____ School Year: _____

Date of Birth: _____ Age: _____ School: _____

Grade: _____ Name of Medication(s): _____

To be completed by student:

- I agree to never share, sell, or distribute my medication to another person.
- I agree to carry the medication in its original, properly labeled prescription/over the counter container.
- I agree to take medication only at the prescribed time/frequency and correct dose.
- I agree to notify my teacher or the school office immediately, if an emergency medication is taken or I do not feel well.
- I agree if I self administer epinephrine, I will seek help immediately following administration.

I am knowledgeable regarding the dose, desired effects, side effects and administration of the medication. I understand, If I do not comply with this agreement that the medication will be confiscated and kept in the main office and the privilege of self administration/possession will be revoked to the extent permitted by law.

Student Signature: _____ Date:_____

To be completed by Parent/Guardian:

- I agree to make sure my child carries his/her medication as prescribed by the authorizing medical provider, while on school property and on field trips.
- I agree to make sure my child understands how and when to properly use their medications as prescribed.
- I agree that medication will be kept in the original properly labeled container and the expiration date is current. I acknowledge it is my responsibility to make sure the medication has not expired, as expired medication can not be administered during school or school sponsored events.
- I agree that in case of any changes in medication, I will complete and provide an updated contract for self-administration/possession of medication form to the school office, and an updated medical care plan, if needed.
- I agree to and understand that this contract is in effect for one (1) calendar school year unless discontinued sooner by my child's authorized medical provider or if my child fails to meet the safety contingencies.

I understand that if my child does not comply with this agreement, their medication will be confiscated and kept in the main office. The privilege of self administration/possession will be revoked to the extent of the law. I will not hold the HAS Board of education, its personnel or employee, responsible for complications related to medication administered pursuant to this form.

Parent/Guardian Signature: _____ Date: _____