HARNETT COUNTY SCHOOLS
Health Services

Student Agreement For Self-Carried Medication
SAC-101

Student: _____ Grade:_____ School:_____

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 a "Request for Medication Administration in School" form. Student's name must appear on inhaler and other medication containers and equipment.

RESPONSIBILITIES

I plan to keep my inhaler, equipment, and/or emergency rescue medication with me at school.

I agree to use my inhaler, equipment, and/or emergency rescue medication in a responsible manner, in accordance with my licensed health care provider's orders.

I will notify the school staff (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 my 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:_____

_____ Written statement, treatment plan and emergency action plan completed by the health care provider and on file at a location that is easily accessible.
_____ Demonstrates correct use/administration.
_____ Recognizes proper and prescribed timing for medication.
_____ Agrees to carry medication.
_____ Knows health condition well.
_____ Keeps a second labeled medication container in health office or main office per G.S. 115C-375.2
_____ Will not share medication or equipment with others.

Comments:
In the event of an emergency and the back-up emergency rescue medication noted above has not been provided to the school, parent contact and/or emergency response services of 9**-1-1** will be utilized.

School Nurse Signature:_____ Date:_____

Principal Signature:_____ Date:_____