AGWSR
Community School District

AGWSR CSD CONTRACT FOR SELF CARRY OF _____

Student Name: _____DOB:_____ Grade: _____ School Year: 25-26

STUDENT
(please check all) □ I plan to keep my medication with me at school rather than in the school health office. □ I agree to use my medication in a responsible manner, in accordance with my physician's orders. □ I will notify the school health office if my medication has been used. □ I will not allow any other person to use my medication. Student's Signature _____ Date _____

PARENT/GUARDIAN
(please check all) *This contract is in effect for the current school year, unless revoked by the physician or student fails to meet the above safety contingencies.* □ I hereby authorize my child to self-administer the above named medication during school hours or school activities as prescribed by the physician. □ I agree to see that my child carries his/her medication as prescribed, that the device contains medication, and that the medication has not expired. □ It has been recommended to me that back-up medication be provided to the Health Office for emergencies. □ I will review the status of the student's condition with the student on a regular basis. □ I release all school personnel and AGWSR CSD from any and all liability in the event any adverse reaction results from the use or administration of this medication. I will hold all school personnel and AGWSR CSD harmless from any liability resulting from allowing my child to self-administer this medication during school hours or school activities. □ I understand my child will carry this medication at school. I also understand my child is entirely responsible for the use of this medication and such use will not be monitored by school personnel. Parent's Signature _____ Date _____

SCHOOL NURSE
□ The above student has demonstrated correct technique for medication use, and understanding of the physician order for use of the medication. □ School staff that have the need to know about the student's condition and the need to carry medication have been notified. Registered Nurse's Signature _____ Date _____

AGWSR Community Schools
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COUGARS

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