



Longleaf School of the Arts

322 Chapanoke road ▪ Raleigh, NC 27603 ▪ (919) 896-8164

STUDENT AGREEMENT FOR SELF-CARRIED MEDICATION

Student Name: _____ Grade: _____

Parent/Guardian: _____ Phone Number: _____

Health Care Provider: _____ Phone Number: _____

Medication: _____ Dosage and Time: _____

Medication is permitted in accordance with the state laws and school policies. Both student's health care provider and parent/guardian must complete the Medical Authorization Form. Student's name must appear on the medications and devices.

STUDENT RESPONSIBILITIES

_____ *I plan to keep my inhaler/equipment, Epinephrine Auto-Injector, or Diabetes medication/equipment with me at school;*

_____ *I agree to use my inhaler/equipment, Epinephrine Auto-Injector, or Diabetes medication/equipment in a responsible manner, in accordance with my licensed health care provider's orders;*

_____ *I will notify the school staff (i.e. nurse, teacher) if I am having more difficulty than usual with my health condition, and*

_____ *I will not allow any other person to use my medication or equipment.*

Student Signature: _____ Date: _____

PARENT RESPONSIBILITIES

_____ *I have reviewed the student responsibilities with my child and acknowledge that my son/daughter is able to self-administer their emergency medication as order by their health care provider.*

Parent/Guardian Signature: _____ Date: _____

----- SECTION BELOW FOR STAFF USE ONLY -----

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|---|--|
| _____ Emergency Action Plan complete and on file at the school | _____ Agrees to carry medication |
| _____ Keeps a back up medication in the health office | _____ Will not share medications or equipment with others |
| _____ Demonstrates proper administration of medication | |

Comments: _____

School Nurse Signature: _____ Date: _____