SELF-MEDICATING STUDENT / PARENT / PHYSICIAN AGREEMENT
(FOR INSULIN, EPI PENS AND ASTHMA MEDICATIONS ONLY)

PHYSICIAN AGREEMENT:

I have provided education to _____
(Student Name)

and given the authorization for self-administration of _____
(Medication)

during school hours and activities.

Physician Signature _____ Date_____

PARENT AGREEMENT:

I, _____, agree that my child, _____
(Parent / Guardian's Name) (Student's Name)

is knowledgeable of his/her treatment and is capable of self-administering the medications.

Parent / Guardian's Signature_____ Date_____

STUDENT AGREEMENT:

I agree and feel competent to take my own insulin, EpiPen, and/or asthma medications as prescribed. I will not at any time share my medication with another student and I will keep it secure from other students.

If I have any problems self-administering my medication or any health problems arise, I will seek assistance from school personnel so as not to jeopardize the health or the safety of myself or my fellow student.

Student's Signature _____ Date _____

Printed Name _____ Date of Birth _____