



Harrells Christian Academy 2019-2020

Student Agreement for Self-Carried Medication (SASM)

Student: _____ Birth Date: _____

Grade: _____ Classroom/ Homeroom Teacher: _____

Parent: _____ Telephone Number: _____

Licensed Health Care Provider: _____ Telephone Number: _____

Medication: _____ Dosage and Time to be given: _____

Medication is permitted in accordance with Harrells Christian Academy's medication policy. The Medication Authorization Form must also be completed by the health care provider, signed by the parent or guardian and kept on file at the school. Student's name must appear on the inhaler/ container as provided by the pharmacy.

Student Responsibilities

- I plan to keep my medication/equipment/EPI pen with me at school (it is the parent's responsibility that back up medication/equipment is provided to the school in case the student does not bring his/her medication and emergency access is necessary).
- I agree to use my inhaler/equipment/PEI pen in a responsible manner, in accordance with my health care provider's instructions.
- I will notify school staff if I am having more difficulty than usual with my health condition.
- I will not allow any other person to use my inhaler/equipment/ EPI pen.
- I am responsible to carry my medication/equipment/ EPI pen to any HCA extracurricular activities.

Harrells Christian Academy, its employees and agents are not liable for any injury arising from a student's possession and self administration of a prescribed inhaler/equipment/EPI pen or other emergency medication nor the misuse of the medication by the prescribed carrier or any individual that may obtain the above stated medication.

Student's Signature: _____ Date: _____

Parent's Signature: _____ Date: _____

To be completed by school nurse and student:

___ Medication Authorization Form complete and on file.

___ Emergency Action Plan complete and on file.

___ Demonstrates correct use/administration of medication. (Student's Initials _____)

___ Recognizes proper and prescribed timing of medication.

___ Agrees to carry medication at school and on HCA extracurricular activities. (Students Initials _____)

___ Knows health condition well

___ Keeps a second labeled container in the office.

___ Will not share medication or equipment with other. (Student's Initials _____)

School Nurse Signature: _____ Date: _____

