SELF-ADMINISTRATION OF MEDICATION CONTRACT

_____ _____

Student's Name Date of Birth: month/day/year

____The parent will:

____The student will: (be specific about every detail)

____The school nurse will:

____The health assistant/secretary staff will:

____The classroom or substitute teacher will:

____The student's physician (PA, NP, PNP, etc.) recommendations are on file.

This contract is good for _____months and will be reviewed for extension on _____. If non-compliance or a change in status occurs, any party may call for an immediate review.

_____ _____ _____

Parent Principal Teacher

_____ _____ _____

Student School Nurse Health Assistant/Secretary