



Student Self-Carry and Self-Administration Contract

For Non-Controlled Prescription and Over-the-Counter (OTC) Medications

A student may be permitted to self-carry and self-administer certain medications depending on their grade level—excluding controlled substances—while on campus to support their health needs. Each student will be individually assessed to ensure they demonstrate the maturity, responsibility, and safety awareness necessary for proper medication management. This privilege may be revoked at any time if the student:

- Fails to follow the terms of this contract,
- Mishandles the medication,
- Shares the medication with others, or
- Is no longer deemed capable of safe self-administration.

Medication Information

- **Medication Name (Prescription or OTC):** _____
- **Dosage:** _____
- **When Medication Is to Be Taken:** _____
- **Medical Condition associated with this medication:**

Accountability & Notification

- Once a medication is self-administered, the **Division Director, Health Coordinator,** and **parent/guardian** must be notified.
- The student is required to **visit the Health Center** following administration, when possible, for documentation and follow-up.
- Following administration of an EpiPen, a 911 call is placed per safety protocols.

Liability Disclaimer

- Parents and students acknowledge that **CSS is not responsible** for lost, stolen, or damaged medications.
- Parents and students agree that **CSS is not liable** for any effects, side effects, or outcomes related to self-administered medication.

Student Agreement

I understand that self-carrying and self-administering medication is a privilege. I agree to the following:

- I will keep my medication secure at all times.
- I will follow my healthcare provider's instructions.
- I will not share my medication with anyone.
- I understand that this privilege may be revoked if I misuse or mishandle my medication.

Student Signature: _____ **Date:** _____

Parent/Guardian Agreement

I agree to the following:

- I will ensure my child carries the correct medication in the original, labeled container with their name on it.
- I will confirm the medication is not expired.
- I understand school staff may revisit this agreement if my child fails to follow the healthcare provider's directions or the terms of this contract.
- I will provide a current medication authorization and/or medical action plan signed by a licensed healthcare provider.

Parent/Guardian Signature: _____ **Date:** _____

Health Coordinator Acknowledgment

I confirm that:

- All required paperwork has been completed and is on file.
- Relevant staff members have been informed of the student's condition and authorized self-carry status.

Health Coordinator Signature: _____ **Date:** _____