West Bloomfield School District
Contract for Self Administration/Possession of Medication

Student's Name: ______________________________________ School Year __________

Date of Birth: ___________________________ School: ____________________________

Age: _____________ Grade: _____________

To be completed by student:

I AGREE TO:

1. Never share, sell or distribute my medication with another person.
2. Carry the medication in its original, properly labeled container.
3. Take medication only at prescribed time, frequency and correct dose.

I am knowledgeable regarding the dose, desired effects, side effects and administration of the medication. I understand if I do not comply with this agreement that the medication will be confiscated and returned to my parent/guardian and privilege of self-administration/possession denied.

Student Signature ________________________________ Date ______________

To be completed by Parent/Guardian:

1. I agree to make sure my child carries his/her medication in its original labeled container and the date is current and not expired.
2. In case of any changes in medication I will complete and provide an updated contract for self administration/possession of medication form as required.
3. I understand that this contract is in effect for one (1) calendar school year unless discontinued by my child's medical provider or if my child fails to meet the above safety contingencies.

Parent/Guardian Signature ________________________________ Date ____________