Student Agreement for Self-Carried Medication (SASM)
High Point Christian Academy 2024-2025

Student Name_____ Birth Date _____

Classroom/Homeroom Teacher_____

Parent/Guardian Name _____Phone_____

Prescribing Physician's Name _____Phone_____

This box to be completed by a physician

Medication/Equipment_____

The above named student may keep the above medication/equipment with him/her at all times. He/she has been instructed in the purpose, administration and side-effects of the medication/equipment. This student shows capability to carry and self-administer/use the above medication/equipment.

_____ _____

PHYSICIAN SIGNATURE **Date**

Self-carried medications are permitted when **both** the Prescription Medication Form (Physician's Statement of Need) and the Student Agreement for Self-Carried Medication Form have been completed and turned in to the Academy office. **Both forms must be signed by the student's physician and parent/guardian.

STUDENT RESPONSIBILITIES

- I plan to keep my medication/equipment listed above with me at school.
- I agree to use my medication/equipment in a responsible manner, in accordance with my health care provider's instructions.
- I agree to notify the school staff (i.e., teacher, nurse) if I am having more difficulty than usual with my health condition.
- I agree that I will not allow any other person to use my medication/equipment.
- I understand that if I use the medication in a manner other than as prescribed, the school may impose disciplinary action according to the school's disciplinary policy.
- I understand that the school will not be responsible for the medication/equipment that I keep with me.

STUDENT'S SIGNATURE_____ Date_____

- I agree that my child may keep the above medication/equipment with him/her at all times.
- I acknowledge that my child is capable of carrying and self-administering the medication listed above.
- I do hereby release High Point Christian Academy, its administrators, staff and faculty from any and all damages for any accident, injury or illness that may result from or related to the self-administration and/or use of this medication/equipment.

PARENT/GUARDIAN SIGNATURE_____Date_____

We accept the parent request and the physician's statement of need. We will permit and assist the student to be responsible, but reserve the right to withdraw the privilege if the student shows signs of irresponsible behavior or there is a safety risk. We will contact the parent as soon as possible in this event.

SCHOOL NURSE SIGNATURE_____Date_____

Reviewed 05/17/2024