DIOCESE OF CHARLOTTE

SELF-MEDICATING STUDENT / PARENT / PHYSICIAN AGREEMENT FOR INSULIN, EPI PENS AND ASTHMA MEDICATION ONLY

PHYSICIAN AGREEMENT:	
I have provided education to	
-	(Student's Name)
and given the authorization for self-administration of	
	(Medication)
during school hours and activities.	
Physician's Signature	Date
PARENT AGREEMENT:	
I,, agree that my (Parent/Guardian's Name)	child,
(Parent/Guardian's Name)	(Student's Name)
is knowledgeable of his/her treatment and is capable of	f self-administering the medication.
Parent / Guardian's Signature	Date
STUDENT AGREEMENT:	
I agree and feel competent to take my own insulin, Ep prescribed. I will not at any time share my medication secure from other students.	
If I have any problems self-administering my medicate assistance from school personnel so not to jeopardize fellow students.	
Student's Signature	Date
Printed Name	Birth Date