Self-Carry and Self Administration of Medication
This student will be allowed to carry the medications and supplies listed on this care plan on his/her person or to keep these medications and supplies in his/her locker or P.E. locker, as we consider him/her responsible. He/she has been instructed in and understands the purpose and appropriate method and frequency of the use of these medications and supplies. If he/she feels the need to use the medications or supplies, he/she may use them and then report to the school nurse or office so that the use of these medications and supplies may be recorded and monitored. He/she will be required to demonstrate proper self-administration technique to the school nurse at the beginning of the year and as she deems necessary.

This Medical Management Plan has been approved by:

_____ _____
Physician/Health Care Provider Signature Date

The Washington School District shall incur no liability as a result of any injury arising from the student's self-management and administration of the medications and procedures listed in this care plan, and the parents/guardians shall indemnify and hold harmless the district and it's employees or agents against any claims arising out of the student's self-management and administration of medications and procedures. We, the undersigned, absolve the Washington School District of any responsibility in safeguarding our child's medication.
Parent Agreement? ☐ Yes ☐ No

Exchange of Information
I give permission for qualified school staff to contact the physician(s) listed on this care plan and discuss my child's medical conditions and treatment as needed.
Parent Agreement? ☐ Yes ☐ No

I give permission to the school nurse, trained personnel, and other designated staff members of **SCHOOL DISTRICT OF WASHINGTON** to perform and carry out the care tasks as outlined by _____'s Medical Management Plan. I also consent to the release of the information contained in this Medical Management Plan to all staff members, First Student Transportation Company, and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety.
Acknowledged and received by:

_____ _____
Parent/Guardian Signature Date

_____ _____
Parent/Guardian Signature Date

Received in Nurses Office on:_____