# CONTRACT TO CARRY/SELF-ADMINISTER MEDICATION
## Over the Counter One Dose Medications Only
## Outdoor Education Only

*This Contract is for students during BFA Outdoor Education who will be bringing one dose of an over-the-counter medication. Any self-carry can be revoked by a physician or if the Student fails to meet contingencies cited below.*

**Student Name _____ DOB _____Date _____**

**Medication _____Purpose of Medication _____ Times(s) to be Given_____**

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**Student (check all boxes):**

- I agree I will only bring one dose per day.
- I agree to keep my Medication with me and use it in a responsible manner as instructed above.
- I will notify the School Representative of my condition if the Medication presents any unusual difficulty.
- I will notify the School Representative if I use the medication.
- I will not give my medication to another student. I will not allow any other student to administer my Medication to him or herself and understand that if I do, I will be disciplined in accordance with the Douglas County School District Re.1's Student Code and Discipline.
- I understand that if I fail to comply with this contract, my privilege to carry and self-administer the Medication may be withdrawn.

**Student Signature: _____ Date: _____**

**Parent or Guardian (check all boxes):**

- I assure that my child, the above-referenced Student, will carry his/her Medication and will not share with any other student.
- I assure you that the medication is in an original container/bag containing the Medication, labeled with the student's name on the packaging and contains Medication that has not expired.
- I agree I will only send one dose per day.
- I have talked to my student about this agreement and my student understands his/her responsibility for bringing and taking the above medications.
- I understand that if my student fails to comply with this contract, the privilege to carry and self-administer the Medication may be withdrawn and may result in disciplinary action.

**Parent Signature: _____ Date:_____**

**Health Room/School Nurse:**

**Health Room/School Nurse Representative Signature: _____ Date: _____**

Return to Ben Franklin Academy via FAX to 303.974.1738 or Email to : health@bfacademy.org