

# **Self-Carry Medication Forms**

If your student 9-12<sup>th</sup> grade would like to carry their own over the counter medication, this form must be signed and a copy must be kept on file with the nurse.

**DEPARTMENT OF DEFENSE EDUCATION ACTIVITY  
STUDENT RETENTION OF MEDICATION**

The public reporting burden for this collection of information is estimated to average 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Washington Headquarters Services, Executive Services Directorate, Information Management Division, 4800 Mark Center Drive, Alexandria, VA 22350-3100 (0704-0495). Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number. RETURN COMPLETED FORM TO THE SCHOOL IN WHICH THE STUDENT IS ENROLLING.

**PRIVACY ACT STATEMENT**

**AUTHORITY:** 10 U.S.C. section, 2164 (Department of Defense Domestic Dependent Elementary and Secondary Schools) and 20 U.S.C. sections 921-932 (Defense dependents' education system).

**PRINCIPAL PURPOSE:** Obtain health-related information about a student enrolling or enrolled in Department of Defense Education Activity (DoDEA) schools and programs to protect and enhance student health and promote a safe school environment. Determine services to be provided for a student in an equal opportunity to participate in public education.

**ROUTINE USES:** DoDEA may release information without prior consent within the Department of Defense (DoD) when needed to perform an official DoD duty, in accordance with 5 U.S.C. section 552a (b) (1). DoDEA also may release information outside the DoD, in accordance with 5 U.S.C. section 552a (b) (2-12), and the "Blanket Routine Uses," published at <http://dpclid.defense.gov/Privacy/SORNsIndex/BlanketRoutineUses.aspx>. Examples of release may include for valid medical, law enforcement or security purposes, or for use in litigation involving the DoD.

**DISCLOSURE:** Voluntary. However, failure to provide the requested information may result in the delay or denial of student services.

**Permission for Student to Retain Control of Medication**

*All sections must be completed and signed.*

**Section 1 To be completed by primary care manager/provider**

Name of student: \_\_\_\_\_ DOB: \_\_\_\_\_ Grade: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Duration of treatment: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Route: \_\_\_\_\_

Possible side effects: \_\_\_\_\_

Times of day/circumstances under which medication is to be given: \_\_\_\_\_

Reason student must have possession of medication at all times: \_\_\_\_\_

Expected results from using the medication: \_\_\_\_\_

Back-up medication needs to be kept in school health office: (Circle one) YES / NO

What student should do if the expected results are not obtained and in case of adverse reaction: \_\_\_\_\_

I have instructed the student and the sponsor/parent/guardian in the proper use and method of administering this medication and the legal consequences of using the medication inconsistently with the prescription or of sharing the medication with anyone else. I have provided the student and his/her sponsor/parent/guardian with the following instructions regarding the symptoms of possible adverse reactions, contraindications, and what to do if student experiences difficulty with or while taking the medication.

The student's medical condition is such that the student must be in possession and control of the medication at all times and be free to administer the medication when needed. **In my opinion, the student possesses sufficient maturity and responsibility to follow my instructions.**

PCM signature & stamp: \_\_\_\_\_ Phone: \_\_\_\_\_ Date: \_\_\_\_\_

**Section 2 To be completed by sponsor/parent/guardian and return to school nurse**

I have read the physician's statement and hereby consent to my dependent's retaining possession at all times of the above prescribed medication. I understand, and have informed my dependent that any illegal use of the medication by the him/her (including the use of the medicine inconsistent with the prescription or sharing the medication with another) will result in disciplinary action. **I will provide extra medication to be kept in the school nurse's office as backup for the medication carried by my dependent.**

Sponsor/Parent/Guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Section 3 To be completed by student**

I understand that I am required to retain possession and control of my prescribed medication in accordance with the terms set forth in Section 1 above. **I have been advised of my responsibility to use my medication only in strict accordance with the prescription.** I understand that any use of my medication inconsistent with the terms of my prescription is an illegal use, as is the sharing of my medication with another person. I agree to carry a pharmacy-labeled container of the medication, to keep a record of the times I use my medication, and to share the information with the nurse/teacher/coach that will help evaluate and monitor the effects of my medication. **During school hours, I will take my medication under the supervision of the school personnel designated by the school nurse and principal.**

Student's signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Instructions reviewed with student by nurse. School nurse's signature:** \_\_\_\_\_