



HEALTH SERVICES

Douglas County School District Re. 1

CONTRACT TO CARRY/SELF-ADMINISTER MEDICATION

This Contract is for students diagnosed with asthma, anaphylaxis, severe allergies, and/or other related life-threatening conditions and is in effect for the current school year unless revoked by a physician or if the Student fails to meet contingencies cited below.

Student Name _____ Date _____
School _____ DOB _____
Medication _____ Purpose of Medication _____

Student:

- I agree to keep my medication with me at school and use it in a responsible manner as instructed by my above-referenced health care provider.
I will notify school office staff if my condition for which I am prescribed the Medication presents any unusual difficulty.
I will notify the office staff if and when I use the Medication.
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 of Conduct 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understand that if I fail to comply with this contract, my privilege to carry and self-administer the Medication may be withdrawn.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 of Signature)

Parent or Guardian:

- I will assure that my child, the above-referenced Student, will carry his/her Medication as prescribed, and that the device containing the Medication and provided to the above-referenced school is appropriately labeled by a pharmacist or health care provider and contains Medication that has not expired.
I will assure that back-up Medication is provided to the health office staff at the above-referenced school for emergencies.
I will review the attached health care plan on a regular basis with my child.

(Parent or Guardian Signature)

(Date of Signature)

School Nurse:

- I will assure that the Student can demonstrate the correct technique for self-administering the Medication.
I will assure that the Student has an understanding of the above-references physician's order pertaining to proper time and dosages for self-administering the Medication.
I agree to assure that appropriate school staff is made aware of the Student's condition and the need for the Student to carry the Medication.
I agree to review on a regular basis with the Student, the status of the Student's asthma/allergy as identified above.
I agree to assign a designee to make a 911 emergency call if and when the Student is exposed in such a way as to require his/her use of epinephrine (Epi-pen).*

(School Nurse Signature)

(Date of Signature)

* Only applies to students who are prescribed epinephrine.