

# BVSD Contract to Carry/Self Administer Medication

*This contract is intended 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 is the Students fails to meet contingencies listed 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 outlined in my treatment plan.
- I will notify school health staff when I use my medication
- I will notify school health staff immediately if my condition for which I am prescribed my medication presents any unusual difficulty.
- I will not allow any other student to administer or use my medication.
- 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understand that if I fail to comply with this contract, my privilege to carry and self-administer the medication may be withdrawn.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/GUARDIAN

- I assure that my child will carry his/her medication as prescribed, that the medication will be in appropriately labeled by a pharmacist or healthcare provider and that the medication has not expired.
- I will assure that back-up medication is provided to the health office for emergencies.
- I will review my child's condition with him/her on a regular basis and communicate any changes to the school.

\_\_\_\_\_  
(Parent/Guardian Signature)

\_\_\_\_\_  
(Date of Signature)

## SCHOOL NURSE

- I will assure the student can demonstrate the correct technique for self-administering the medication.
- I will assure the student has an understanding of the proper time and dosages for self-administering the medication.
- I agree that appropriate school staff is notified of the student's condition and the need for the student to carry the medication.

\_\_\_\_\_  
(School Nurse Signature)

\_\_\_\_\_  
(Date of Signature)