Livermore Valley Joint Unified School District

CONTRACT TO CARRY AND SELF ADMINISTER MEDICATIONS

Pursuant to Education Code Section 49423(b)(2) I authorize my student to carry and self-administer the life-sustaining medication(s) indicated below.

Student :_____ Grade/Teacher:_____DOB:_____
Parent(s):_____ Contact Phone Number(s):_____School:_____

I. Medication(s) Prescribed by the Authorized Health Care Provider:

Inhaler: _____ Epi-Pen:_____ Glucagon:_____ Insulin: _____

Instructions for Use:_____

The above named student is under my care and needs to carry this medication with him/her while at school. I agree that the student is capable of self-administration and is able to manage this medication responsibly.

Name of Health Care Provider:_____ Phone/fax #_____

Address or stamp:

Signature of the provider:_____Date:_____

II. Student Agreement:

____This medication will be with me at all times (backpack, pocket, purse, etc…), including off campus events.

____I will not share this medication with anyone.

____I will alert the teacher/coach when I have used my medication.

____I will come to the office if I need my medication more than once in a day.

____Other:

Student Signature:_____Date:_____

III. Parent Agreement:

I request that my child be allowed to carry and self-administer his/her prescribed medication(s) as recommended by the authorized medical provider. I understand that it is my responsibility to notify the school if my child's health status changes. Changes in medication dosages or procedures must be received in writing from the physician. I agree that the school district, it's employees and agents shall not be held liable for any loss, damage, injury or liability of any kind to any person caused or arising from acts, omissions, or negligence of district employees. I give my consent for the school nurse or designated school personnel to consult with the above provider regarding questions that may arise with regard to the above medication/medical condition. My signature below also permits the distribution of my student's health history and school picture to those deemed necessary for his or her care during school hours.

Parent or Guardian Signature:_____Date:_____