

Self Administration of Medication Contract

Student Name: _____ DOB _____ Grade _____

School _____

Medication: name & dosage: _____

indications for use: _____

STUDENT AGREEMENT

1. I will use my medication as I have been instructed and trained by my doctor. (doctor's orders attached)
2. Following self administration of my medicine, I will resume school activities unless:
___ a) It is required that I immediately notify an adult staff member of having used my medication and the need for **911 to be called** (Required for Epi Pen use.)

___ b) I continue to have symptoms and/or do not feel well after using my medication. I will then inform an adult (teacher/office staff) of my need for assistance.
3. I will keep my medication on my person or in my possession at all times and I will not let anyone else handle or use my medication.
4. My medication will be labeled with my first and last name and kept in its original container.

Student signature _____ Date _____

PARENT AGREEMENT

1. As the parent/guardian of the above named student, I declare that my student can correctly administer the medication as prescribed without supervision of school personnel. I release the Fremont Unified School District Board of Education and any of their officers, employees, and agents from any responsibility or liability for not providing or supervising this service.
2. I will notify the school office immediately of any changes in my student's health status or medication orders.
3. I understand that this contract is valid for the current school year.
4. I understand that the privilege of carrying medication on campus may be revoked if this contract is violated and that my student may be subject to disciplinary action if the medication is used in a manner other than prescribed and agreed to in this contract. {FUSD Medication Policy 5141.21}

Parent/Guardian signature _____ Date _____

Administrator signature _____ Title _____ Date _____

Copy for : Student to carry on his/her person, Parent, Health File, and Principal