

Pleasanton Unified School District

School: _____ Phone #: _____ Fax #: _____

Contract to Carry Life Sustaining Medications on Campus

Student's name _____ DOB: _____ ID #: _____

Parents: _____ Contact number: _____

A PUSD medication form or Asthma Action Plan authorized by student's health care provider is *required* for the life sustaining medication/equipment that you request to carry.

I. Medication(s) Prescribed by the Authorized Health Care Provider:
 Inhaler: _____ EpiPen _____ Glucagon _____ Insulin _____ Other: _____

The 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.

Print Name of the Health Care Provider: _____ Phone and fax #: _____
 Address or stamp: _____

Signature of the provider: _____ Date: _____

II. Student agreements:

- I understand that I am to keep this medication and/or equipment, with this contract on my person (pocket, purse, backpack, fanny pack) at all times except when in use.
- I will not share these medications or equipment with anyone under any circumstances.
- I will alert the teacher /coach that I am having problem symptoms. Assistance may be needed if my symptoms persist or get worse after the first dose of medication.
- I will notify the Health Office if I need to use my inhaler more than once during a school day.
- I will follow my Asthma Action Plan, ISHP or other health plan on file in the Health Office.
- I will renew this request every school year; I will make sure my coach knows these orders.
- I understand that non-compliance may result in a change in this plan. If I fail to have the medication (i.e.: a rescue inhaler) I may have to provide a back-up supply for Health Office.
- Other: _____

Student's Signature: _____ Date: _____

III. Parent agreements:

This signifies that I give permission for my child to carry this medication and/or equipment. I agree to the above conditions and will make certain that my child takes responsibility for taking the medication as prescribed. I also agree that District, its officers, 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 the District, its officers. Employees and agents related to the self administered medication by my child.

I am providing a back-up medication or inhaler for the Health Office as well. YES NO

Parent's Signature: _____ Date: _____

Reviewed by: _____ District Nurse Health Clerk Liaison Site Administrator