Tustin Unified School District

Health Services:
Contract for Student to Self-Carry and Self-Administer Authorized Medication

Student Name: _____ Date of Birth: _____

School: _____Grade:_____Teacher:_____SchoolYear: _____

This Medication Contract has been designed to ensure student safety and well-being. Persons indicated below will assume designated responsibilities in an agreement which allows this student to:

Self-Carry and Self-Administer _____at _____
(Name of Medication) (Specify Time or When Needed)

The Parent Will…	**Provide** written parent and physician authorization on appropriate form. **Monitor/Verify** that student takes medication as prescribed knowing that school personnel cannot monitor self-administration. **Provide** back-up medication in Health Office for emergency use. • I am choosing not to provide this medication to the Health Office as back up. _____(parent signature) **Inform** School Nurse within 24 hours of any change in medication treatment regime. **Authorize** telephone communication between School Nurse and physician as needed.
The Student Will…	**Carry** medication safely along with a copy of this contract in_____ **Take** medication independently and discreetly and keep parent informed of usage. **Notify** Health Office if medication use does not relieve symptoms when given as ordered. **Notify** Health Office immediately if medication is lost or stolen. **MAY NOT** share medication with other students (this is subject to disciplinary action). Other:
The School Nurse Will…	**Review** Parent/Physician Request For Medication order. **Develop** any related Individualized Healthcare Plan (IHP) as needed. **Inform** appropriate school personnel as needed (such as Health Clerk, Office Staff, Teachers, Noon Supervisors, Bus Drivers, etc.)
The Health Clerk/Office Staff Will…	**Be Aware** of the student's Medication Contract. **Maintain** copies of the Request for Medication and Self-Carry Contract in the Health Office. **Notify** both School Nurse and parent in the event of unusual circumstances.
Other School Personnel Will…	**Report** unusual circumstances to Health Office immediately.

This contract is valid for a maximum of one year, and must be accompanied by a completed
"PARENT/GUARDIAN AND AUTHORIZED HEALTH CARE PROVIDER REQUEST FOR MEDICATION"

If non-compliance or a change in status occurs, the student, parent or School Nurse may call for immediate review.
We have read and agree to the contents of this Medication Contract:

_____ _____

Student Signature **Date** **Parent Signature** **Date**

SCHOOL STAFF USE ONLY THIS BOX

Contract Received by: _____ _____ _____
Signature of school staff member Job Title Date

_____ **Verify** that "Health Care Provider Initials" to carry/self-administer are present on the Medication Request Form
(Staff Initial)

Expiration Date of carried medication: _____ (Parents are responsible for replacing expired medication.)

Student given completed copies: ____ Parent/Guardian and Authorized Healthcare Provider Request for Medication.
____Contract for Student to Self-Carry and Self-Administer Authorized Medication

Original copy of contract to be kept in medication book with medication order in the health office.

05/04/2015
Adapted from OCDE form: Contract for Self Administration of Medication 10/2010