

Sugar Creek Charter High School

Contract for Self-Carried Medication

Student Name: _____ Grade: _____

Physician: _____ Telephone #: _____

Medication: _____ Dosage: _____ Time: _____

Medication is permitted in accord with district policy. Student's physician must authorize self-carried/administered medication. Student name must appear on the medication (inhaler, container).

FOR SELF-ADMINISTRATION – PHYSICIAN, PLEASE COMPLETE AND SIGN

The above named student has demonstrated proper technique and understands the use of (please circle) **Asthma/allergic reaction:** MDI (*Metered Dose Inhaler) *MDI with spacer *Peak Flow Meter *Epi-Pen **Diabetes:** *Insulin, and may carry and self-administer this medication for asthma, allergic reaction, or diabetes.

*Parent/guardian must provide an extra inhaler be kept at school in case of emergency.

*Parent/guardian should provide a copy of student's Asthma Action Plan and peak flow meter for use at school.

Physician's Signature

Date

I agree to bring/send the medication in a properly labeled original container.

Signed: _____
(Parent or Guardian) (Date) (Telephone Number)

PARENT/GUARDIAN PERMISSION

I give permission for the exchange of information (verbal, written, or faxed) between the above named health care provider and the Sugar Creek Charter High School nurse as needed. I understand that this information will remain confidential.

Signed: _____
(Parent or Guardian) (Date) (Telephone Number)

I request that my child be allowed to carry his/her medication and be responsible for its proper storage and use. I will support my child to follow the above agreement and if s/he does not, I will be contacted and we will develop a new plan.

Signed: _____
(Parent or Guardian) (Date) (Daytime telephone numbers)