



# Pearland Independent School District

## Self-Carried Asthma or Anaphylaxis Medication Contract

Student: \_\_\_\_\_ DOB: \_\_\_\_\_ Grade: \_\_\_\_\_

Parent Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Physician: \_\_\_\_\_ Telephone: \_\_\_\_\_

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Time: \_\_\_\_\_

Medication is permitted in accordance with district policy. The student's physician must authorize self-carried, self-administered medication. A prescription label with the student's name must appear on the medication container.

### Responsibilities for carrying emergency medication

Observed by RN

Yes No

\_\_\_\_\_ Health Care Action Plan Complete

\_\_\_\_\_ Student demonstrates correct use of prescribed medication

\_\_\_\_\_ Student verbalizes proper and prescribed timing for medication

\_\_\_\_\_ Student agrees to not share medication with others

\_\_\_\_\_ Student agrees to keep medication in an appropriate and safe location

\_\_\_\_\_ Student agrees to come directly to the health clinic symptoms do not improve after using medication.

\_\_\_\_\_ A second labeled container will be kept in the Health Office (recommended, not required).

The student does / does not demonstrate the specified responsibilities. The student may carry the medication unless he/she fails to follow the above agreement.

\_\_\_\_\_  
Student Signature/ Date

\_\_\_\_\_  
School Nurse Signature/ Date

I give permission for my child to carry the medication specified above. I understand that s/he must follow the responsibilities listed above. I will notify the school of changes in medication or my child's condition and support my child to follow the above agreement. I will be contacted and to develop a new plan if the agreement is not followed. I acknowledge that PISD will not be liable for injury arising from the student's possession and self-administration of allergy/ asthma medication.

\_\_\_\_\_  
Parent/ Guardian and Date