Permission to Self-Carry a Daily Dose of Prescription Medication at School

NOTE: This form is to be completed each school year, in addition to a medication authorization order from the student's provider with prescriptive authority.

Student Name: _____ **DOB:** _____ **Grade:** _____

School: _____

Medication Name/Dosage/Frequency/Route: _____

STUDENT ACKNOWLEDGMENT:

- I agree to always keep my medication with me while attending school and/or attending school-sponsored events.
- I agree to use & self-administer my medication responsibly, per my provider's orders.
- I understand when and where to seek adult guidance regarding the medication or symptoms they are experiencing before or after using the medication.
- I agree to not allow any other person to use my medication.
- I agree that failure to follow the terms of this Agreement and applicable school board policy will result in loss of the privilege to possess and self-administer my medication.

Student Name _____ Student Signature _____ Date _____

PARENT/GUARDIAN ACKNOWLEDGEMENT

This contract is in effect for the current school year unless revoked by the provider or if the student fails to meet the above safety contingencies.

- I agree to see that my student carries their medication as prescribed by their provider at school and/or at school-sponsored events and activities and that the medication is not expired.
- I agree to provide the school health clinic with a signed Health Care Provider order for this medication.
- It has been recommended to me that backup medication be provided to the school health clinic for emergencies.

Parent/Guardian Name _____ Parent/Guardian Signature _____ Date _____

SCHOOL ACKNOWLEDGMENT

- The school nurse has reviewed the medication authorization order provided by the parent/guardian and signed by the student's health care provider and the parent/guardian.
- The school nurse will keep all appropriate records associated with the student's self-administration of medication.
- Appropriate school staff who need to know about the student's medical condition and their need to self-carry this medication have been notified.
- The school nurse has reviewed with the student when to notify staff and seek help if their medication is not working or they need more support.

School Nurse Name _____ School Nurse Signature _____ Date _____

Pursuant to C.R.S. 22-1-119.5, a student with asthma, severe allergies, or other related, life-threatening conditions may possess and self- administer medication to treat the condition if the student has an approved treatment plan. In accordance with state law and school board policy, a student may be granted permission to self-carry and self-administer asthma inhalant medication. As such, the Cherry Creek School District requires that parents and students complete this Agreement prior to granting a student permission to possess and self-administer asthma inhalant medication.