Bethel Public Schools Health Services
Contract to Carry and Self-Administration of
Bronchodilators or Epinephrine Auto-Injectors or Pancreatic Enzymes

Student's Name:_____ Date: _____

School:_____ Grade: _____

PHYSICIAN'S ORDER AND STUDENT COMPETENCY STATEMENT

I AM TREATING THIS STUDENT FOR (DIAGNOSIS)_____ AND

HAVE DETERMINED THAT HE/SHE REQUIRES MEDICATION DURING SCHOOL HOURS.

MEDICATION:_____ DOSE:_____

SCHEDULE FOR ADMINISTRATION:_____

STUDENT:_____ HAS BEEN INSTRUCTED IN THE PROPER METHOD

OF SELF-ADMINISTRATION OF (MEDICATION)_____. HE/SHE IS ABLE

TO CARRY AND ADMINISTER HIS/HER OWN MEDICATION IN THE APPROPRIATE WAY.

PHYSICIAN'S SIGNATURE:_____ DATE:_____

PARENT AUTHORIZATION
TO SELF-MEDICATE AND STUDENT COMPETENCY STATEMENT

I UNDERSTAND THAT STATE LAW REQUIRES PARENTS TO PROVIDE AN EMERGENCY SUPPLY OF THIS MEDICATION TO THE SCHOOL FOR ADMINISTRATION SHOULD MY CHILD'S MEDICATION BE UNAVAILABLE.

I UNDERSTAND THAT UNDER STATE LAW THE BOARD OF EDUCATION, THE SCHOOL DISTRICT OR EMPLOYEES OF THE DISTRICT SHALL NOT BE LIABLE TO THE STUDENT OR THE STUDENT'S PARENT OR GUARDIAN FOR CIVIL DAMAGES FOR ANY PERSONAL INJURIES TO THE STUDENT WHICH RESULT FROM THE SELF-ADMINISTRATION OF MEDICATION BY THE STUDENT.

I BELIEVE THAT_____IS COMPETENT TO CARRY AND ADMINISTER HIS/HER MEDICATION AT THE APPROPRIATE TIME AND IN THE APPROPRIATE WAY. I GIVE PERMISSION FOR HIM/HER TO SELF-ADMINISTER HIS/HER MEDICATION AS INDICATED ABOVE.

PARENT SIGNATURE_____ DATE_____
NURSE SIGNATURE_____ DATE_____