

Health Services

Student Name: _____ Medication Name: _____

As specified in Adams 12 Five Star Schools District Policy 5420, there are a few specific and significant situations when a Healthcare Provider will write directions for a student to keep medication with them at all times, even during the school day. **Considerations for self-carry should include the student's age and capability to self-administer medication as well as the student's ability to comply with the district's policy on carrying medication.**

SAFETY AND PROTECTION IS PARAMOUNT FOR ALL STUDENTS AT SCHOOL AT ALL TIMES – THEREFORE THERE ARE CERTAIN RESPONSIBILITIES THAT THE FAMILY AND STUDENT MUST ASSUME WHEN THE STUDENT WILL CARRY MEDICATION DURING THE SCHOOL DAY. By signing below, I/we agree to comply with the terms of this plan and the provisions of Adams 12 Five Star Schools District Policy 5420. Parent/guardian releases Adams 12 Five Star Schools, its employees, agents, and volunteers from any and all liability related to the student's self-administration of ordered medication except that parent/guardian does not waive any claim related to the willful or wanton misconduct by the district or its employees, agents, and volunteers.

STUDENT

- ☐ I plan to keep my Epinephrine with me at school rather than in the school Health Office. It may not be left unattended in any classroom, student desk, or backpack (exception may be made for locked PE lockers).
- ☐ I agree to use my Epinephrine in a responsible manner, in accordance with my Healthcare Provider's orders.
- ☐ I will notify the school Health Office immediately if I use my Epinephrine.
- ☐ I will NOT ALLOW any other person (adult or student) to use my Epinephrine.

Student Signature _____ Date _____

PARENT/GUARDIAN

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

- ☐ I agree to see that my child carries his/her medication as prescribed and that the medication has not expired.
- ☐ It has been recommended to me that a back-up Epinephrine be provided to the Health Office for emergencies.
- ☐ I agree to review the status of my child's health with the District Registered Nurse on a regular basis and as needed to implement this treatment plan.

Parent Signature _____ Date _____

SCHOOL NURSE

- ☐ The above student has demonstrated correct technique for epinephrine use and an understanding of the Healthcare Provider's order for emergency use of the Epinephrine delivery device.
- ☐ School staff that have the need to know about the student's condition and the need to carry medication have been notified.

District Registered Nurse Signature _____ Date _____