



Union Public Schools Health Services Permission for Students to
Carry and Self-Administer Albuterol Inhaler, Epinephrine or Pancreatic Enzymes

Student: _____ D.O.B. _____

Teacher: _____ Grade: _____

To Be Completed by Student

Student Agreement:

I have been instructed in the proper use of my prescription medication and fully understand how and when to use this medication. I will always carry my medication with me and will not allow another student to use my medication under any circumstances. I will go to the nurse's office after every use of my medication if it is my Albuterol inhaler or Epinephrine.

Student Signature: _____ Date: _____

To Be Completed by Parent

Parental Permission and Responsibilities:

I authorize my child to carry and self-administer their prescribed medication at school. My child demonstrates a full understanding of the proper use of their prescribed medication.

I take sole responsibility for:

Ensuring the medication is properly labeled with a pharmacy label with prescriptive information for my child.
Ensuring the student always carries their prescribed medication on his/her person. I have instructed my child to go to the nurse's office after self-administration of the medication if it is their Albuterol inhaler or Epinephrine.

Providing backup medication to be kept in the nurse's office.

Updating emergency contact information as changes occur.

I release the School District and its employees and agents from any legal responsibility related to my child's possession and self-administration of their prescribed medication. I understand this "Exception to the Medication Policy" may be revoked if the agreement is not adhered to by all parties.

Parent/Guardian Signature: _____ Date: _____

To Be Completed by Physician

Physician Authorization:

It is my professional opinion that the student named above should be permitted to carry and self-administer their prescribed medication as prescribed on the prescription label. The student has been instructed in and demonstrates an understanding of the proper use of their prescribed medication.

Students Name: _____ School Year: _____

Diagnosis: _____

Name & Strength of Medication: *Note if ordered PRN, the interval for repetition of the dose must be specified.*

Side Effects to Expect: _____

Side Effects to Report: _____

Physician Name: (please print) _____

Physician Phone: _____ Physician Fax: _____

Physician Signature: _____ Date: _____

This contract will remain valid for the current school year: _____.

