#  **Student’s name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_ Grade\_\_\_\_\_\_**

# **School: CASIMIR MIDDLE Health Office #: 310-533-4498x4783 School Year: 2022-2023**

## I. A TUSD medication form or Asthma Action Plan, with doctor’s orders, and Health Office approval is *required* for the life sustaining medication/equipment that you request to carry.

**II. Student agreements:**

* I understand that I am to keep this medication and/or equipment, with this contract on my person (pocket, purse, backpack, fanny pack) at all times except when in use.
* I will not share these medications or equipment with anyone under any circumstances.
* I will alert the teacher /coach that I am having problem symptoms. Assistance may be needed if my symptoms persist or get worse after the first dose of medication.
* I will notify the Health Office if I need to use my inhaler more than once during a school day.
* I will follow my Asthma Action Plan, ISHP or other health plan on file in the Health Office.
* I will renew this request every school year; I will make sure my coach knows these orders.
* I understand that non-compliance may result in a change in this plan. If I fail to have the medication (i.e.: a rescue inhaler) I may have to provide a back-up supply for Health Office.
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

**III. Parent agreements:**

This signifies that I give permission for my child to carry this *life sustaining medication and/or equipment. I agree to the above conditions.*  I will immediately notify the District Nurse of changes in my child’s condition, medication(s), Asthma Action Plan, ISHP or other health plan.

* I am providing a back-up medication or inhaler for the Health Office as well. YES NO

Parent’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

## IV. Health Office ONLY This Contract applies to *life sustaining medications only* (specify):

|  |  |  |
| --- | --- | --- |
| * Albuterol Inhaler
* Ventolin Inhaler
* Proventil Inhaler
* Intal Inhaler
* Aerochamber
* Peak Flow meter
 | * EpiPen

(requires sign-off by District Nurse) | * Other (requires sign-off by District Nurse)
 |

Givephysician name/date of order to carry medication: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

The student has the inhaler or medication on their person and is aware of the proper usage: **\_\_\_\_\_**

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Health Clerk or District Nurse) Date: \_\_\_\_\_\_\_\_\_\_\_