Torrance Unified School District
2335 Plaza del Amo Torrance, CA 90509

Contract to Carry Life Sustaining Medications on Campus

Student's name _____DOB: _____ Grade_____

School: **CASIMIR MIDDLE Health Office #: 310-533-4498x4783 School Year: 2023-2024**

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: _____

❑ 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)

Give physician 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: _____