HEALTH/NURSING SERVICES

Las Virgenes Unified School District
Pupil Services Department
4111 Las Virgenes Road, Calabasas, CA 91302
Phone: (818) 878-5216 Fax: (818) 878-0601

Contract to Carry Life Sustaining Medication on Campus

Students name:_____ **DOB:**_____ **Grade:**_____

School:_____ **Health ofc #:**_____ **School Year:**_____

I. **An LVUSD authorization for medication form or Food Allergy & Anaphylaxis Emergency Care Plan (FARE), 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/health clerk that I am having problematic 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 FARE Care Plan or other health care plan on file in the Health Office.
- ❑ I will renew this request every school year; I will make sure my coach is aware of these orders.
- ❑ I understand that non-compliance may result in a change in this plan. If I fail to have the medication (ie, rescue inhaler) I may have to provide a back-up supply for the Health Office.
- ❑ Other: _____

Students 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), FARE Care plan, or other health care 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)

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:_____