



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	EpiPen (requires sign off by District Nurse)	Other: (requires sign off by District Nurse)
Proventil Inhaler	Intal Inhaler		
Aerochamber	Peak Flow meter		

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: _____