PERMISSION AND CONTRACT TO SELF-CARRY AND SELF-ADMINISTER MEDICATION

**This document is for students who are self-carrying Medication to address their health concern(s) and is in effect for the current school year unless revoked by an authorized medical provider or if the Student fails to meet contingencies cited below.

Student Name: DOB: School: Date:

For Medical Provider

Medication: _____ Dosage: _____ Route: _____

Time/Frequency: _____ Purpose: _____

Through my consultation with the above-named student's parent(s)/guardian(s), as well as my own assessment of the student ("Student"), I have determined that the Student is able to identify his/her correct medication, demonstrate correct self-administration of the above listed medication ("Medication"), and has knowledge of the required dosage and timing/frequency of use of the Medications. The Student has been instructed in the purpose, appropriate method, and frequency of use of the Medication and is capable of self-administering the Medication. A new form must be completed for all medication changes.

Signature: _____ Date: _____

Printed Name: _____ Phone Number: _____

For Parent

It is understood that the Medication will be self-administered solely at the request of, and as an accommodation to, the undersigned parent(s)/guardian(s). The unsigned parent(s)/guardian(s) hereby agree(s) to the release of the Douglas County School District Re. 1 and its personnel from any and all claim(s), which they now have or may hereafter have arising relating to an act or omission of the Student's use of the Medication.

The parent agrees to:

- I will assure that my child, the above referenced Student, will carry his/her Medication as prescribed, and that the device containing the Medication and provided to the above referenced school is appropriately labeled by a pharmacist or healthcare provider and contains Medication that has not expired.
- I understand that I have the option to provide additional Medication to the health office for the above referenced school for emergencies.
- I understand that it is my responsibility to review the medical provider's order(s)/instruction(s) for the Medication on a regular basis.

Parent/Guardian Signature: _____ Date: _____

For Student

The Student agrees to:

- Keep my Medication with me at school and use it in a responsible manner as instructed by my above referenced medical provider.
- Notify a staff member if I need assistance or if I have used an emergency medication (e.g. epinephrine, inhaler, etc.)
- Not allow any other student to administer my Medication to him/herself and understand that if I do, I will be appropriately disciplined in accordance with the Douglas County School District Re. 1's Student Code and Discipline
- Understand that if I fail to comply with this contract, my privilege to carry and self-administer the Medication may be withdrawn.

Student Signature: _____ Date: _____

For School Nurse Consultant

The School Nurse Consultant:

- Will meet with the student to observe the student's technique in self-administering the Medication and to check for understanding of the medical provider's order(s)/instruction(s).
- Notify appropriate school staff of student's condition and that student will be self-carrying their Medication.

School Nurse Consultant Signature: _____ Date: _____

Corresponding District policy JLCD is located at:
Revised: April 4, 2006, to conform with current law; December 8, 2005; May 16, 2006; February 20, 2020
Cross Ref: JLCD
Legal Refs: C.R.S. 22-1-119
Douglas County School District Re 1, Castle Rock, Colorado

Douglas County School District
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