SCHOOL YEAR

20___ / 20___

This form is valid only for the current school year, including summer school.

FREMONT UNIFIED SCHOOL DISTRICT
Office of Student Support Services

Form E

SELF-ADMINISTRATION OF MEDICATION CONTRACT

Student's Name (Last, First) _____ **Date of Birth** _____

School _____ **Gr** ____ **Room** _____ **Sex** ☐ **Male** ☐ **Female**

Special Education (IEP) ☐ **No** ☐ **Yes** **504 Plan** ☐ **No** ☐ **Yes**

STUDENT AGREEMENT

1. I will use my medication as I have been instructed and trained by my healthcare provider (see attached orders).
2. Following self-administration of my medication:
   - If I have self-administered an epinephrine, I will immediately notify an adult staff member and **911 will be called**.
   - I will resume school activities unless I continue to have symptoms and/or do not feel well after using my medication. I will inform an adult (teacher/office staff) if I need assistance.
3. My medication will have a pharmacy label (or my first and last lame if an over-the-counter medication) and will be kept in the original container.
4. I will keep my medication on my person or in my possession at all times and I will not let anyone handle or use my medication. I will keep a copy of this self-administration contract (Form E) and my medication orders (Form D) with my medication.

Signature of Student: _____ Date: _____

PARENT/GUARDIAN AGREEMENT

1. As the parent/guardian of the above named student, I confirm that my student has been trained to administer the medication as prescribed without supervision of school personnel.
2. I will notify the school office immediately, in writing, of any changes in my student's health status or medication order.
3. I understand this contract is valid for the current school year only, including summer school.
4. I understand that the privilege of carrying medication on campus may be revoked if this contract is violated. My student may be subject to disciplinary action if the medication is used in a manner other than prescribed. (FUSD BP/AR 5141.21)
5. I release the Fremont Unified School District Board of Education and any of their officers, employees, and agents from any liability or responsibility for supervision of the student during self-administration of this medication.
6. In the event my student is unable to self-administer rescue medication, the physician's orders will be followed.

Signature of Parent/Guardian: _____ Date: _____

For School Use Only

☐ **Physician's Orders Attached & Dated** _____

Reviewed/Competency Verified by School Nurse _____ **Date** _____

Adminsitrator's Signature _____ **Date** _____

DISTRIBUTION: Copy 1–Parent/Guardian Copy 2–Student Copy 3-Student's Green Health Binder Copy 4–Student's Cum File Copy 5 - Administrator