WELD COUNTY SCHOOL DISTRICT RE-1

# PARENT/LEGAL GUARDIAN'S RELEASE FOR STUDENT TO CARRY AND SELF-ADMINISTER MEDICATION AT SCHOOL AND AUTHORIZED PRESCRIBER SIGNED ORDER

Student Name: _____ Medication Name: _____

There are situations when a Healthcare Provider will write directions for a student to always keep medication with them, even during the school day. **Considerations to self-carry should include the student's age and capability to self-administer medication as well as the student's ability to comply with the district's policy on carrying medication.**

**SAFETY AND PROTECTION IS PARAMOUNT FOR ALL STUDENTS AT SCHOOL AT ALL TIMES- THEREFORE THERE ARE CERTAIN RESPONSIBILITIES THAT THE FAMILY AND STUDENT MUST ASSUME WHEN THE STUDENT WILL CARRY MEDICATION DURING THE SCHOOL DAY.** By signing below, I/we agree to comply with the terms of this plan and the provisions of JLCD. Parent/guardian releases Weld County School District RE-1 Schools, its employees, agents, and the volunteers from all liability related to the student's self-administration of ordered medication except that the parent/guardian does not waive any claim related to the willful or wanton misconduct by the district of its employees, agents, volunteers.

## CONTRACT FOR STUDENT TO CARRY AND SELF-ADMINISTER MEDICATION

This contract is in effect for the current school year unless revoked by the Healthcare Provider or if the student fails to meet the specified safety contingencies.

- Healthcare Provider confirms that the student has been instructed in **and** is capable of self-carry and self-administration of the ordered medication.
- The Healthcare Provider has completed the appropriate medication order.
  **HEALTHCARE PROVIDER SIGNATURE:** _____ Date: _____
- I plan to keep my medication with me at school rather than in the school health office. It may not be left unattended in any classroom, student desk, or backpack (exception may be made for locked lockers).
- I agree to use my medication in a responsible manner, in accordance with my Healthcare Providers order.
- I agree to notify the school Health Assistant or other appropriate staff if I am having difficulty and my symptoms are not relieved.
- I agree to NOT ALLOW any other person (adult or student) to use my medication.
  **STUDENT SIGNATURE:** _____ Date: _____
- I agree to see that my child carries his/her medication as prescribed, that the medication is in the proper over the counter or pharmacy labeled container, and that the medication is not expired.
- It has been recommended to me that back-up medication should be provided to the school Health Office for emergencies.
- I agree to review the status of my child's health with the District Registered Nurse on a regular basis and as needed to implement this treatment plan.
  **PARENT SIGNATURE:** _____ Date: _____
- The above-named student has demonstrated the correct technique for medication use.
- The above-named student verbalized an understanding of following the Healthcare Provider's order for time and dosage for the prescribed medication.
- Appropriate school district personnel have been notified about the student's medical condition and their need to carry medication while at school.
  **DISTRICT REGISTERED NURSE SIGNATURE:** _____ Date: _____