


School _____ Grade _____ School Year _____ DOB _____	 Orange County Department of Education CONTRACT FOR SELF ADMINISTRATION OF MEDICATION FOR _____ <i>Student Name</i>	Authorization Dates Physician _____ Parent _____ Name of Supervisor S.N. _____
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This Medication Contract has been designed to ensure student safety and well being. Persons indicated below will assume designated responsibilities in an agreement which allows this student to:

Self Administer _____ at _____
(Name of Medication) (Specify Time - or - When Needed)

The Parent Will...	Provide written parent and physician authorization – and – Monitor/Verify that student takes medication as prescribed knowing that school personnel cannot monitor self administration. Provide back-up medication in Health Office for emergency use. Inform School Nurse within 24 hours of any change in medication treatment regime Contact School Nurse in May to discuss plans for the next school year Authorize telephone communication between School Nurse and physician as needed
The Student Will...	Demonstrate/Explain to School Nurse, correct use of the medication including frequency. Store medication safely along with a copy of this Contract in _____ Take medication independently and discreetly – and – Keep parent informed. Notify Health Office immediately if medication is lost or stolen. Refrain from sharing medication with other students (this is subject to disciplinary action). Other: _____
The School Nurse Will...	Develop the authorized Medication Contract and any related Individualized Healthcare and Support plan (IHSP) – and – Maintain written parent and physician authorization on file. Inform appropriate school personnel (such as Health Clerk, Office Staff, Teachers, Noon Supervisors, Bus Drivers, etc.) Monitor contract implementation on a regular basis.
The Health Clerk/Office Staff Will...	Be Aware of the student’s Medication Contract. Notify both School Nurse and parent in the event of unusual circumstances.
Other “Need To Know Personnel” Will...	Be Aware of the student’s Medication Contract. (For Classroom Teachers) Leave information for any substitute teacher. Report unusual circumstances to Health Office immediately.

VERIFICATION OF MEDICATION CONTRACT			
Review Date for continuation of this contract will be: _____ <i>This contract is valid for a maximum of one year, and must be accompanied by a completed “PARENT/GUARDIAN AND AUTHORIZED HEALTH CARE PROVIDER REQUEST FOR MEDICATION”</i>			
“Need To Know” Personnel will be informed of Medication Contract by School Nurse as of _____ Date School Nurse Signature Date			
If non-compliance or a change in status occurs, the student, parent or School Nurse may call for immediate review. We have read and agree to the contents of this Medication Contract:			
_____ Student Signature	_____ Date	_____ Parent Signature	_____ Date