School _____ **Grade** _____ **School Year** _____ **DOB** _____	Orange County Department of Education **CONTRACT FOR SELF ADMINISTRATION OF MEDICATION FOR** _____ *Student Name*	**Authorization Dates** **Physician** _____ **Parent** _____ **Name of Supervisor S.N.** _____

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: _____

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"

"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 many call for immediate review. We have read and agree to the contents of this Medication Contract:

_____ _____

Student Signature Date Parent Signature Date

This form may be used at the discretion of the school district and is not mandated for use by OCDE. *Revised 6/10/15*