SALIDA UNION SCHOOL DISTRICT

4801 Sisk Rd., Salida, CA 95368 * (209) 545-0339

ASTHMA CONTRACT

Name of Student:____________________________ Grade:_____ Teacher:________________________

Name of Health Care Provider:_____________________________________Phone:_______________

Name of Medication:_______________________________Dosage:____________Time:____________

Medication must be dispensed per Salida Union School District's medication at school procedures. Student inhalers must be labeled with the student's name.

Responsibilities for carrying respiratory inhalers:

Yes	No	
❑	❑	"Parent Consent for Self Administration of Medication" form has been completed.
❑	❑	"Physician Request for Self Administration of Medication at School" form has been completed.
❑	❑	Student demonstrates correct use of inhaler.
❑	❑	Student agrees not to share inhaler with other students.
❑	❑	Student agrees to carry inhaler with him/her at all times.
❑	❑	Students who continue to have difficulty breathing, wheezing, or experiencing chest tightness after using inhaler, must check into the nurse's office.
❑	❑	Parent has provided a second inhaler to be kept in the health office. If a second inhaler is not provided and student needs medication but for whatever reason doesn't possess the required medication, the district will contact Emergency Services (911).

Student signature:__________________________________ Date:____________________________

School nurse signature:______________________________ Date:____________________________

Comments:____

____

MY CHILD WILL BE RESPONSIBLE FOR CARRYING THIS RESPIRATORY INHALER DURING SCHOOL HOURS AND WILL SELF-ADMINISTER HIS/HER MEDICATION. MY CHILD AGREES TO FOLLOW THE DISTRICT'S PROCEDURES CONCERNING THE HANDLING AND ADMINISTRATION OF THIS MEDICATION.

Parent/Guardian's Name (print):____

Parent/Guardian's Signature:______________________________ Date:__________________________

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PARENT CONSENT FOR SELF-ADMINISTRATION OF MEDICATION AND RELEASE OF LIABILITY

I hereby consent for my child_________________________, to self-administer the following medication during the regular school day or when attending school related activities

_____ Auto-injectable epinephrine

_____ Inhaled asthma medication

I also consent to disclosure of identifiable health information from the health care provider to the school nurse or other designated school personnel.

I acknowledge that I have an obligation to notify the school if my child's medication, dosage, frequency of administration or reason for administration changes during the school year.

I, on behalf of myself, my child, our heirs, executors and assigns, hereby agree to indemnify and hold harmless, release and covenant not to sue the District, its officers, employees, and agents, for any and all liability, claim or cause of action of any nature whatsoever, including but not limited to personal injury or death, which may result from my child's self-administration of medication.

____
Date

____
Signature of Parent/Guardian

____
Printed Name of Parent/Guardian

Date_________________________Reviewed by School Nurse

____
Complete
Signature of Nurse

☐ Asthma Contract

Date_________________________Reviewed by Principal

____
Signature of Principal

This request MUST be updated annually and medication claimed within one week beyond the end of the school year.

SALIDA UNION SCHOOL DISTRICT

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(209) 545-0339

Epinephrine Auto-Injector Contract

Name of Student: ______________________ Grade: ________ Teacher: ______________

Name of Health Care Provider: ______________________ Phone: ______________

Name of Medication: ______________ Dosage: ______________ Time: ________

Medication must be dispensed per Salida Union School District's medication at school procedures. Student Epinephrine Auto-Injectors must be labeled with the student's name.

Responsibilities for carrying Epinephrine Auto-Injectors:

Yes No

☐ ☐ "Parent Consent for Self Administration of Medication" form has been completed.

☐ ☐ "Physician Request for Self Administration of Medication a School" form has been completed.

☐ ☐ Student demonstrates correct use of Epinephrine Auto-Injector.

☐ ☐ Student agrees not to share Epinephrine Auto-Injector with other students.

☐ ☐ Student agrees to carry Epinephrine Auto-Injector with him at all times.

☐ ☐ Student who uses Epinephrine Auto-Injector must notify an adult so Emergency Services (911) can be called.

☐ ☐ Parent has provided a second Epinephrine Auto-Injector to be kept in the health office. If a second Epinephrine Auto-Injector is not provided and student needs medication, but for whatever reason doesn't possess the required medication, the district will contact Emergency Services (911).

Student Signature: ______________________ Date: ______________

School Nurse Signature: ______________________ Date: ______________

Comments: ____

____

MY CHILD WILL BE RESPONSIBLE FOR CARRYING THIS EPINEPHRINE AUTO-INJECTOR DURING SCHOOL HOURS AND WILL SELF-ADMINISTER HIS/HER MEDICATION. MY CHILD AGREES TO FOLLOW THE DISTRICT'S PROCEDURES CONCERING THE HANDING AND ADMINSTRATION OF THEIS MEDCIATION.

Parent/Guardian's Name (print): ______________________________

Parent/Guardian's Signature: ______________________ Date: ______________

SALIDA UNION SCHOOL DISTRICT

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PARENT CONSENT
FOR SELF-ADMINISTRATION OF MEDICATION
AND RELEASE OF LIABILITY

I hereby consent for my child_______________________, to self-administer the following medication during the regular school day or when attending school related activities

_____ Auto-injectable epinephrine _____Inhaled asthma medication

I also consent to disclosure of identifiable health information from the health care provider to the school nurse or other designated school personnel.

I acknowledge that I have an obligation to notify the school if my child's medication, dosage, frequency of administration or reason for administration changes during the school year.

I, on behalf of myself, my child, our heirs, executors and assigns, hereby agree to indemnify and hold harmless, release and covenant not to sue the District, its officers, employees, and agents, for any and all liability, claim or cause of action of any nature whatsoever, including but not limited to personal injury or death, which may result from my child's self-administration of medication.

____
Date

____
Signature of Parent/Guardian

____
Printed Name of Parent/Guardian

Date__________________________Reviewed by School Nurse

______________________________ ☐ Asthma Contract
Complete
Signature of Nurse

Date__________________________Reviewed by Principal

____
Signature of Principal

This request MUST be updated annually and medication claimed within one week beyond the end of the school year.