

Livermore Valley Joint Unified School District

CONTRACT TO CARRY AND SELF ADMINISTER MEDICATIONS

Pursuant to Education Code Section 49423(b)(2) I authorize my student to carry and self-administer the life-sustaining medication(s) indicated below.

Student: _____ Grade/Teacher: _____ DOB: _____
Parent(s): _____ Contact Phone Number(s): _____ School: _____

I. Medication(s) Prescribed by the Authorized Medical Provider:

Inhaler: _____ Epi-Pen: _____ Glucagon/Baqsimi: _____ Insulin: _____

Instructions for Use: _____

The above named student is under my care and needs to carry this medication with him/her while at school. I agree that the student is capable of self-administration and is able to manage this medication responsibly.

Name of Authorized Medical Provider: _____ Phone/fax # _____

Address or stamp:

Signature of the provider: _____ Date: _____

II. Student Agreement (both student and parent initial next to each statement below):

This medication will be with me at all