CAPITAL CHRISTIAN SCHOOL

9470 Micron Avenue Sacramento, CA 95827
PHONE 916/856-5611 FAX 916/856-5960

MEDICATION SELF-ADMINISTRATION CONTRACT

For Middle and High School Students Only

Student: _____ Grade: _____ School: _____

CCS recognizes that the health needs of the above named student may require the use of certain unscheduled rescue medications (i.e. insulin, epinephrine, inhalers). In order to accommodate that need, CCS will allow the MHS student to self-administer the necessary medication upon request by the student, parent, and physician provided that the student has demonstrated the ability to carry and use the medication in a responsible, appropriate and safe manner. The medication must be labeled and in the original container with a back-up supply in the school health office. This contract must be renewed annually or when there is a change in the medication, dose or time given. ***This contract must accompany a CCS "Release for the Administration of Student Medication" form and be on file in the school health office.***

Medical condition: _____

Medication_____ Dose _____ Route ____ Frequency _____

STUDENT, PARENT AND PHYSICIAN CONTRACT

1. Student has demonstrated to the physician and parent/guardian correct use of the medication.
2. Student agrees never to share the medication with another person.
3. Student agrees to go to the school health office immediately if there is not marked improvement after taking the medication. ***NOTE: If the medication is for severe allergic reactions, the student will seek additional medical attention immediately following administration.***
4. We the parents of the above mentioned student, agree to assume all responsibility and liability for the above mentioned medication when it is brought on campus by the student.

Student signature: _____ Date: _____

Parent/Guardian signature: _____ Date: _____

Physician signature: _____ Date: _____

Reviewed by: _____ Date: _____
ADMINISTRATOR

_____ Date: _____
OTHER

CAPITAL CHRISTIAN SCHOOL
9470 Micron Avenue X Sacramento, CA 95827
School Nurse (916) 856-5633 ext 1249 XFax (916) 856-5950

RELEASE FOR THE ADMINISTRATION OF STUDENT MEDICATION:

School personnel will cooperate with parents when a physician *prescribes* medication to be taken during school hours and is required for the student=s health. However, the primary responsibility for the student taking medication at school rests entirely with the student and the student's parents. Students in middle and high school need to be responsible to come to the nurse's office during the time their medication is due. The school nurse or other designated personnel may assist the student in taking medication provided that the parent has complied with the school=s requirements. Medication can only be given between 8:00 AM & 3:00 PM, emergencies excepted.

ALL MEDICATION MUST BE IN THE ORIGINAL CONTAINER, NOT EXPIRED AND CORRECTLY PRESCRIBED (with pharmacy label) FOR THE INDICATED STUDENT ONLY. ALL MEDICATION MUST BE KEPT IN NURSE'S OFFICE UNLESS THE STUDENT HAS A SELF ADMINISTRATION CONTRACT* ON FILE IN THE NURSE'S OFFICE. THIS FORM IS GOOD FOR ONE MEDICATION AND FOR ONE STUDENT. Please submit additional forms for each medication, and each student. (*Middle High students may be allowed to carry certain emergency medications with them, but only after parent, physician and school nurse approval)

LONG TERM (longer than two weeks) PRESCRIPTION MEDICATION
Medication that must be given for longer than two weeks must be accompanied by this medication release form *signed by the prescribing physician*; or a written statement *from the prescribing physician* indicating the student's name, date, medication, dose, route, reason, and time(s) for which the medication is to be given.

SHORT TERM (1-14 days) PRESCRIPTION MEDICATION
Medication that must be given for less than two weeks must be accompanied by this medication release form; or a written statement from the parent indicating the student's name, start and discontinue dates, medication, dose, route, reason, and time(s) for which the medication is to be given.

OVER THE COUNTER MEDICATION: Over the counter medication will only be given when it is accompanied by the "Parent Release for Non-Prescriptive Over-the-Counter Medication in School" form *signed by the parent* indicating the students name, date, medication, dose, route, reason, and time(s) for which the medication is to be given. NO EXCEPTIONS, PLEASE.

SELF-ADMINISTRATION OF MEDICATION: Only Students in MHS **may** be allowed to carry emergency medication. In order to do so, the parent and physician must also complete the SELF-ADMINISTRATION OF MEDICATION CONTRACT in addition to this form.

STUDENT _____ GRADE _____ TEACHER _____

Please assist my child in taking the provided medication as indicated. The school nurse or designee has my permission to communicate with my child's physician, and may counsel with school personnel regarding the possible effects of the medication on my child. I will notify the school immediately if any change in the medication is necessary. I understand the medication will be discarded after two weeks of discontinued use.

_____ _____ _____

PARENT/GUARDIAN SIGNATURE **DATE** **DAY PHONE**

MEDICATION _____ DOSE _____

TIME _____ AM _____ PM _____ ONLY AS NEEDED EVERY _____ HOURS

ROUTE: ☐ ORAL ☐ INHALE ☐ EYE (R L) ☐ EAR (R L) ☐ OTHER

REASON _____ SIDE EFFECTS __

_____

GIVE MEDICATION UNTIL: _____ (date) OR _____ UNTIL NOTIFIED

PHYSICIAN _____ ***PHONE*** _____
PHYSICIAN'S SIGNATURE _____ ***Date:*** _____