Elevate Oklahoma

Self Administration Contract

Student Name: _____ School Year: _____

☐ Inhaler: _____

☐ EpiPen: _____

☐ Benadryl: _____

☐ I agree to use my ___ in a responsible manner, in accordance with my physician's orders.
☐ I understand that is my responsibility and agree to bring my ___ to all school sponsored activities.
☐ I will notify the Executive Director: Mrs. Sanders if I need to use my ____.
☐ I will notify the Executive Director: Mrs. Sanders immediately if I am experiencing any allergy symptoms for which my EpiPen/Benadryl and/or other allergy medications might be necessary.
☐ I will notify the Executive Director: Mrs. Sanders immediately if my inhaler has not provided relief and/or improvement of asthma symptoms.
☐ I will not allow any other person to use my ___.
☐ I will keep my ___ in
  ☐ (please describe the backpack, lunchbox, etc. and where in the container).
  _____
  ☐ EO's medical cubby in the office.
☐ I understand that EO reserves the right to withdraw permission at any time if I do not demonstrate responsible behavior in carrying and/or taking this medication.

Student Signature: _____ Date: _____
Parent/Guardian Signature: _____ Date: _____

This contract is in effect for the current school year _____ unless revoked by the physician or the student fails to meet the above safety contingencies.

☐ I agree to oversee that my child carries his/her medication as prescribed, that the device contains medication, and that the medication has not expired.
☐ I certify that my student has asthma and is under the care of a physician who has prescribed an inhaler for the management of asthma, and my child has been instructed in the proper method of self-administration of the inhaler.
☐ I certify that my student has _____ allergy/ies and is under the care of a physician who has prescribed an EpiPen(s)/Benadryl for the treatment of his/her allergy, and my child has been instructed in the proper method of self-administration of the EpiPen/Benadryl.
☐ A back-up Inhaler:

- ☐ Will be kept in EO's medical cubby
- ☐ Will not be kept in EO's medical cubby

☐ A back-up EpiPen/Benadryl:

- ☐ Will be kept in EO's medical cubby
- ☐ Will not be kept in EO's medical cubby

☐ I will communicate conditions or medication updates to the Executive Director: Mrs. Sanders.

☐ I understand that EO reserves the right to withdraw permission at any time if my child does not demonstrate responsible behavior in carrying and/or taking this medication.

☐ I acknowledge that EO and its staff shall incur no liability as a result of injury arising from the self-administration of medication by my child.

☐ I relieve EO of responsibility for benefits or consequences of the medication and acknowledge that EO bears no responsibility for ensuring the medication is taken when needed.

Parent/Guardian Signature: _____ Date: _____

EO does not employ/contract any medical personnel (aides, nurses, and/or physicians). We are committing to doing what we can to advocate, support, protect and help your student to the best of our abilities. All of our staff will be made aware of these selections to help towards this end. We have also received basic training to help us be more sensitive to the needs of their condition and treatment. In the event of use of any medication, EO will notify you as soon as possible.