Torrance Unified School District
2335 Plaza del Amo Torrance, CA 90509

Contract to Carry Life Sustaining Medications on Campus

Student's name _____DOB: _____ Grade_____

School _____Health Office #: _____School Year _____

I. A TUSD medication form or Asthma Action Plan, with doctor's orders, and Health Office approval is ***required*** for the life sustaining medication/equipment that you request to carry.

II. Student agreements:

- I understand that I am to keep this medication and/or equipment, with this contract on my person (pocket, purse, backpack, fanny pack) at all times except when in use.
- I will not share these medications or equipment with anyone under any circumstances.
- I will alert the teacher /coach that I am having problem symptoms. Assistance may be needed if my symptoms persist or get worse after the first dose of medication.
- I will notify the Health Office if I need to use my inhaler more than once during a school day.
- I will follow my Asthma Action Plan, ISHP or other health plan on file in the Health Office.
- I will renew this request every school year; I will make sure my coach knows these orders.
- I understand that non-compliance may result in a change in this plan. If I fail to have the medication (i.e.: a rescue inhaler) I may have to provide a back-up supply for Health Office.
- Other: _____

Student's Signature: _____ Date: _____

III. Parent agreements:
This signifies that I give permission for my child to carry this *life sustaining medication and/or equipment. I agree to the above conditions.* I will immediately notify the District Nurse of changes in my child's condition, medication(s), Asthma Action Plan, ISHP or other health plan.

- I am providing a back-up medication or inhaler for the Health Office as well. YES NO

Parent's Signature: _____Date: _____

IV. Health Office ONLY This Contract applies to ***life sustaining medications only*** (specify):

q Albuterol Inhaler q Ventolin Inhaler q Proventil Inhaler q Intal Inhaler q Aerochamber q Peak Flow meter	q EpiPen (requires sign-off by District Nurse)	q Other (requires sign-off by District Nurse)

Give physician name/date of order to carry medication: _____

The student has the inhaler or medication on their person and is aware of the proper usage: _____

Signature: _____ (Health Clerk or District Nurse) Date: _____

Original: Medication file with the MD order
Copy: student (parent)