**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:** South High School **Health Office:** (310) 972-4352 **School Year** _____

I. A TUSD medication form, physician's order, or Asthma Action Plan and Health Office approval is ***required*** in order for a student to carry life sustaining medication/equipment.

**II. Student agreements:**

- □ I understand that I am to keep this medication and/or equipment, along with a copy of 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 is aware of these orders.
- □ I understand that non-compliance may result in a change in this plan. If I fail to have the medication with me (i.e. rescue inhaler), I may have to provide a back-up supply for the Health Office.
- □ Other: _____

Student's Signature: _____ Date: _____

**III. Parent agreements:**

This signifies that I give permission for my child to carry his/her life sustaining medication and/or equipment. I agree to the above conditions. I will notify the District Nurse immediately 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 (please circle)

Parent's Signature: _____ Date: _____

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

| | | |
|---|---|---|
| ❑ Albuterol Inhaler<br>❑ Ventolin Inhaler<br>❑ ProAir Inhaler<br>❑ Xopenex Inhaler<br>❑ Aerochamber<br>❑ Peak Flow meter<br>❑ _____ | Requires signature/approval of District Nurse:<br>❑ EpiPen<br>(requires sign-off by District Nurse)<br>❑ Auvi-Q<br>❑ Other Epinephrine Autoinjector _____ | Requires signature/approval of District Nurse:<br>❑ Diabetic supplies (specify):<br>_____<br>_____<br>❑ Other _____ |

Physician name: _____ Date of order to carry medication: _____

*By signing below, I acknowledge that I have verified that the student has the appropriate medication/equipment on their person and is aware of the proper usage:*

Signature: _____ Health Assistant/LVN Date: _____
Signature: _____ District Nurse Date: _____

Original: Medication Log Book with the physician's order
Copy: Student
Updated 7/2/2024