Fallbrook Union Elementary School District
321 N. Iowa Street Fallbrook, CA 92028-2108 760.731.5400 www.fuesd.org

Candace Singh
Superintendent

Agreement for Student to Self-Medicate at School

Name of Student: _____ Date of Birth: _____

School: _____ Grade: ____ Teacher: _____ Room#: _____

My parents, physician and I request that I be allowed to carry _____
Name of medication

at school so that I may use it quickly when needed.

- My physician and parents feet that my health and welfare is dependent on using the medication quickly when I need it and that going to the health office for this may take too long for my safety.
- My physician agrees to instruct the pharmacist to attach the identifying label with my name directly to the medication container that I will be carrying (not the box).
- My parents agree to keep me supplied with the medication as ordered by my physician on the Physician Statement and immediately notify the Health Care Specialist / Health Technician if there are any changes in the physician's orders as required by the district medication policy.
- I agree to:
    - Keep the medication in my pocket or school back pack at all times unless it is in use.
    - Report to the Health Care Specialist / Health Technician as soon as possible when I use my medication
    - Immediately report to the Health Care Specialist / Health Technician if my medication is lost.
    - Keep my medication ONLY for my use and NOT share with anyone else.
    - Follow my physician's instructions exactly when I use my medication.

My parent, physician and I understand that if we do not adhere to this agreement, I will lose the privilege of carrying and self-administering my medication at school. We understand that this is for my protection and for the protection of other students at my school.

Student Name (Print)	Student Signature	Date
Parent Name (Print)	Parent Signature	Date
Physician Name (Print)	Physician Signature	Date