

Emergency Medication Self-Carry Agreement

This plan is in accordance with HB 1688 from the 2001 Texas Legislative Session. This bill allows students to self-administer emergency rescue medication while at school or school functions with permission from parents, physicians, and the school nurse. This form is good only for the current school year and must be completed at the beginning of every school year

Student Name: _____ Grade: _____ Date of birth: _____
Address: _____
Parent/Guardian: _____ Phone # _____ Phone # _____
Emergency contact: _____ Phone # _____ Phone # _____

A. TO BE COMPLETED BY PHYSICIAN LICENSED BY THE STATE OF TEXAS

I have instructed _____ (student's name) in the proper way to use his/her medication. It is my professional opinion that this student should be allowed to carry and self-administer the following emergency rescue medication on school property or at school-related events:

Rescue Medications

Medication: _____ Purpose: _____
Dosage: _____ When to Use: _____

Medication: _____ Purpose: _____
Dosage: _____ When to Use: _____

For asthma inhalers only! May repeat for severe breathing difficulty _____ times _____ minutes apart

Physician Signature _____ Date _____ Print
Name: _____ Phone: _____ Fax _____

B. TO BE COMPLETED BY PARENT OR LEGAL GUARDIAN I agree with the recommendations of my child's physician as noted above and have informed my child that he/she may carry his/her emergency rescue medication while on school property or at school related events according to school district policy and the student agreement below. I authorize the school's registered nurse and the prescribing physician to discuss and/or clarify this medication order, or in the interest of the student's health, to discuss his/her response to the prescribed medication as required by the Nurse Practice Act and Medical Practice Acts of Texas:

Parent/Guardian

Signature: _____ Date: _____

C. TO BE COMPLETED BY STUDENT AND SCHOOL NURSE

- _____ Student knows name, correct dosage, purpose, expected effects and side effects of medication.
- _____ Student demonstrates correct use/administration of medication.
- _____ Student understands that medication must have prescription label affixed, that authorization from the school nurse must be carried, that allowing anyone else to use this medication will result in disciplinary action, and that the privilege of carrying this medication can be rescinded for violating any part of this agreement.

Student will carry/keep medication (specify location) _____

Student signature: _____ School nurse signature: _____ Date _____