**KILGORE ISD**
**CONTRACT FOR SELF-CARRIED MEDICATION**

STUDENT______________________________ DOB __________ GRADE_________
MEDICATION_________________________DOSE_____________TIME___________

*Kilgore ISD permits a responsible, trained student to carry and/or self-administer medication for asthma (wheezing), severe allergic (anaphylactic) reaction, or diabetes on his/her person for immediate use in a life-threatening situation, or for conditions that require the student to have continuous access to medication.

## RESPONSIBILITIES

**Physician Authorization:** (INITIAL BESIDE EACH ONE)

**School Year Start Date: ______________ School Year Stop Date:____________**

________ Student is knowledgeable about the medication and how to administer it.

________ Student has the skills to safely possess and use medication.

________ Student may self-administer the medication.

Printed Name of Physician________________ Physician Signature_________________

Clinic Address __________________ Phone Number ______________ Date_________

**Parent/Guardian Authorization:**

- I request that the above medication(s) be given during school hours as ordered by this student's physician. I also request the medication(s) be given on field trips or other school sponsored activities, as prescribed.
- I release school personnel from liability in the event adverse reactions result from taking the medication(s). I will notify the school of any change in the medication(s).
- I give permission for the school nurse to communicate with the student's teachers about the student's condition.
- I give permission for the school nurse to consult with the above named student's physician/licensed prescriber regarding any questions that arise with regard to the listed medication(s).

- My son/daughter may self-administer his/her medication(s).

Parent/Guardian Signature________________________________ Date___________