FAUQUIER COUNTY PUBLIC SCHOOLS

ANNUAL CONTRACT FOR SELF-ADMINISTRATION OF MEDICATION

PHYSICIAN OR PRESCRIBER

Name of Student_____Grade/Room_____

Name of Medication_____

Frequency of Use_____

Duration of Order_____

Health Care Plan specific for the student is provided for the school. Yes_____ No_____

Please list any directions or comments specific to the student and include any recommended emergency response.

_____

_____

_____

Physician's Signature_____Phone_____Date_____

PARENT/GUARDIAN I have provided the school with the orders and health care plan from the physician. I understand that I will not hold the school board or its employees responsible for any negative outcomes from the self administration of medication. In the event an individual is exposed to my child's bodily fluids, I will have my child's blood tested for HIV, Hepatitis B and Hepatitis C or other organisms. Furthermore, I understand that the principal may revoke the permission to possess and self-administer the medication for the remainder of the school year, if it is determined that my student is not safely and effectively self-administering the medication.

_____ _____ _____

Parent/Guardian's Signature Phone Number Date

TO BE COMPLETED BY THE SCHOOL HEALTH STAFF CHECKLIST: Documentation of this agreement is on file in the school clinic.

_____Physician Prescribed orders

_____Individualized Health Care Plan

_____Emergency Transportation Plan

_____Demonstrated ability by the student

_____Parent Signature

_____Teacher(s) Informed