Allergy Self Carry Contract **School: _____Grade: _____**

STUDENT :_____ DOB:_____

I plan to keep my Epi-pen with me at school rather than in the school health office.

I agree to use my Epi-pen in a responsible manner, in accordance with my physician's orders.

I will notify the school health office immediately if my Epi-pen has been used.

I will not allow any other person to use my Epi-pen.

Student's Signature _____Date _____

PARENT/GUARDIAN:_____

This contract is in effect for the current school year unless revoked by the physician or the student fails to meet the above safety contingencies.

I agree to see that my child carries his/her medication as prescribed, that the device contains medication, and that the medication has not expired.

It has been recommended to me that a back-up Epi-pen be provided to the Health Office for emergencies.

I will review the status of the student's allergy with the student on a regular basis as agreed in the health care plan.

I will provide the school a signed medication authorization for this medication.

Guardian's Signature _____Date _____

Nurse Consultant _____ School_____

The above student has demonstrated correct technique for Epi-pen use, an understanding of the physician order for emergency use of the Epi-pen .
School staff that have the need to know about the student's condition and the need to carry medication have been notified.
I will review the medication authorization provided by the parent and signed by the parent and health care provider.

Nurse Consultant's Signature _____Date _____

School Administrator's Signature: _____ Date: _____
Teacher's Signature: _____ Date: _____
Teacher's Signature: _____ Date: _____

Health Assistant Signature: _____ Date: _____