

STUDENT: _____ **DOB:** _____

- ☐ I plan to keep my epinephrine with me at school rather than in the school health office.
- ☐ I agree to use my epinephrine in a responsible manner, in accordance with my physician's orders.
- ☐ I will notify the school health office immediately if my epinephrine has been used.
- ☐ I will not allow any other person to use my epinephrine.

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 epinephrine 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.

Parent's Signature _____ Date _____

Nurse Consultant: _____

- ☐ The above student has demonstrated correct technique for epinephrine use, an understanding of the physician order for emergency use of the epinephrine.
- ☐ 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: _____