Bentonville Schools

CONTRACT TO SELF-CARRY Epi-PEN, INHALER &/or INSULIN/GLUCAGON

STUDENT NAME:	
Epi – Pen ☐ NA	☐ 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.**
Inhaler ☐ NA	☐ I plan to keep my **Inhaler** with me at school rather than in the school health office. ☐ I agree to use my **Inhaler** in a responsible manner, in accordance with my physician's orders. ☐ I will notify the school health office immediately if my **Inhaler** has not provided relief and/or improvement of asthma symptoms. ☐ I will not allow any other person to use my **Inhaler**.
Insulin/Glucagon ☐ NA	☐ I plan to keep my **Insulin/Glucagon** with me at school rather than in the school health office. ☐ I agree to use my **Insulin/Glucagon** in a responsible manner, in accordance with my physician's orders. ☐ I will notify the school health office immediately if my **Glucagon** has been used. ☐ I will not allow any other person to use my **Insulin/Glucagon**

Student Signature:	Date:

PHYSICIAN NAME:
This student has the knowledge and skill to carry and use**:** ☐ **Epi-Pen**_____ This student has the knowledge and skill to carry and use: ☐ **Inhaler**_____ Please contact the Healthcare Provider and parent if student is using quick relief medication more than _____times a week (not including pre-exercise treatment). This student has the knowledge and skill to carry and use**:** ☐ **Insulin/Glucagon**_____

Physician Signature:	Date:

PARENT/GUARDIAN NAME:	
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 medications (Inhaler/Epi-Pen/Insulin) 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 treatment plan. ☐ I will review the status of the student's asthma symptoms with the student on a regular basis and will contact the doctor for changes in the student's asthma symptoms. ☐ I will review the status of the student's diabetes with the student on a regular basis and will contact the doctor for changes in the student's diabetes symptoms.	
Parent/Guardian Signature:	Date:

SCHOOL NURSE:
☐ The above student has demonstrated correct technique for Epi-pen use & an understanding of the physician order for emergency use of the Epi-pen. ☐ The above student has demonstrated correct technique for Inhaler use, an understanding of the physician order for use of the Inhaler. ☐ The above student has demonstrated correct technique for Insulin/Glucagon administration, an understanding of the physician order for use of the Insulin ☐ School staff that have the need to know about the student's condition and the need to carry medication have been notified.

RN Signature:	Date:

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