SELF-CARRY AND SELF-ADMINISTRATION OF EPIPEN AND/OR INHALER

Student Agreement

I agree to:

• Follow my licensed healthcare provider’s medication administrations instructions according to the current medication authorization and health care plan(s).
• Use the correct medication administration technique (after return demonstration is approved by school nurse).
• Not allow anyone else to use my medication(s).
• Keep my pharmacy labeled EpiPen and/or Inhaler with me during regular school hours.
• Inform my parent/guardian when I am close to running out of medication or the EpiPen/Inhaler is close to the expiration date on the label.
• Notify my school nurse and school staff if the following occur:
  o My symptoms continue or get worse after taking the medication.
  o My symptoms reoccur during the same school day.
  o I suspect that I am experiencing side effects from my medication.
  o I’ve used my EpiPen due to an allergic reaction.
  o Other______________________________
• I am knowledgeable about my prescribed medicine’s proper use and the side effects.
• I understand that permission to self-carry and self-administer my EpiPen/Inhaler is designed to enhance my self-care skills as I move toward increased independence.
• I understand that permission for possession and self-administration of my EpiPen/Inhaler will be re-evaluated if I am unable to abide by the listed criteria above.

________________________________________
Signature of Student

________________________________________
Date

________________________________________
Print name of Student

I have read and concur with the above student agreement.

________________________________________
Signature of Parent/Guardian

________________________________________
Date

________________________________________
Print name of Parent/Guardian

The student has demonstrated knowledge about and proper use of his/her emergency medications.

________________________________________
Signature of School Nurse

________________________________________
Date

2/2020