EpiPen® Self Carry Contract – LPS 2016-2017

Name:	D.O.B.	
School/Teacher:	Grade:	

This contract between the school, the school nurse consultant, the student, and the student's parents or legal guardian will be established by assigning levels of responsibility for each individual. This contract will accompany the Health Care Action Plan for severe allergy management. All parties agree that noncompliance with the contract may result in withdrawal of the privilege.

STUDENT AGREEMENT

- ☐ I will not allow any classmate to have access to my medication.
- ☐ I will inform school staff whenever I feel I am having allergy symptoms, or my allergy reaction needs the administration of my EpiPen®, as outlined in my Health Care Action Plan.
- ☐ I will keep my medication: ☐ in my possession at all times ☐ in the school health office ☐ in an accessible and secure location (located in _____)

_____	_____	_____
√ **STUDENT SIGNATURE**	**PRINT STUDENT'S NAME**	**DATE**

PARENT/GUARDIAN AGREEMENT

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

- ☐ I agree that my student can recognize potential life threatening allergic symptoms (anaphylaxis) as outlined in the Health Care Action Plan, and understands the importance of seeking immediate help of school staff member(s) that may assist in the administration of the EpiPen® and request for emergency personnel (911)
- ☐ I agree to see that my student carries his/her medication as prescribed, that the device contains medication, and the medication has not expired.
- ☐ I agree to provide backup medication to the health office: ☐ Antihistamine ☐ EpiPen®
- ☐ I agree to provide current emergency contact information to school staff.

_____	_____	_____
√ **PARENT/GUARDIAN SIGNATURE**	**PRINT PARENT/GUARDIAN NAME**	**DATE**

SCHOOL NURSE AGREEMENT

- ☐ I have assessed this student's ability to recognize potential life threatening allergic symptoms (anaphylaxis) as outlined in the health care plan, understand the importance of seeking immediate help of school staff member(s) that may assist in the administration of the EpiPen® and request for emergency personnel (911). I agree with the designated self care.
- ☐ The above student has demonstrated correct technique for EpiPen® use.
- ☐ School staff that have the need to know about the student's condition and the need to carry medication have been notified.

_____		_____
SCHOOL NURSE SIGNATURE	**PRINT NURSE'S NAME**	**DATE**

DESIGNATED SCHOOL ADMINISTRATOR AGREEMENT

I am aware of this student's ability to recognize potential life threatening allergic symptoms (anaphylaxis) as outlined in the Health Care Action Plan, understand the importance of seeking immediate help of school staff member(s) that may assist in the administration of the EpiPen® and request for emergency personnel (911). I agree with the designated self care.

_____	_____	_____
SCHOOL ADMINISTRATOR SIGNATURE	**PRINT ADMINISTRATOR'S NAME**	**DATE**