Self-Administration of Epipen

**Student Agreement**

I agree to:

∙ Follow my physician/licensed prescriber’s medication orders.

∙ Be knowledgeable of prescribed medicine’s proper use and side effects. ●Demonstrate proper use of an epipen trainer.

∙ Not allow anyone else to use my medication.

∙ Keep my epipen with me at all times, in a safe place that is not accessible to other students. If another location is more appropriate or desired, please explain (for example backpack, athletic bag…):

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∙ Notify the school nurse or school personnel immediately upon use of my epipen, so that 911 will be called at once.

∙ I understand that permission for possession and self-administration of my medication may be suspended if I am unable to maintain the criteria listed above.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of Student Date

I have read the above student agreement.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ Signature of Parent/Guardian

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date

The student has demonstrated knowledge about and proper use of his/her epipen. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of Licensed School Nurse

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date