# Contract / Procedure For Self-Administration of EPI-PEN

STUDENT: _____ BIRTHDATE: _____

PHYSICIAN: _____ PHYSICIAN TELEPHONE: _____

NAME OF MEDICATION: _____

DOSAGE: _____ TIME: _____

**Medication must be dispensed following the County's Medication Policy. The Epi-Pen must be labeled with the student's name and dosage.**

| *RESPONSIBILITIES FOR CARRYING EPI-PEN* | | |
|---|---|---|
| Yes | No | Severe allergy information form & medication form returned. |
| Yes | No | Demonstrates correct use of Epi-Pen (using a Epi-Pen trainer) |
| Yes | No | Acknowledges proper timing for Epi-Pen use. |
| Yes | No | Agrees not to share or allow others to use their Epi-Pen. |
| Yes | No | Will keep Epi-Pen with belongings where it is not accessible to other students. |
| Yes | No | Agrees to come directly to the Office (accompanied by a "buddy") if Epi-Pen is used. 911 MUST be called for transport to the Emergency Room for physician evaluation. |
| Yes | No | Provides a second Epi-Pen to be kept in the school medication cabinet (Required at the elementary, recommended at the secondary.) |

*The student does / does not demonstrate meeting above specified responsibilities.*
*The privilege of carrying the inhaler will / will not be allowed.*

_____ _____

Student Signature Date Nurse's Signature Date

My child will be responsible for carrying this EPI-PEN and will self-administer. My child agrees to follow the county's procedures concerning the handling and administration of this medication. ***It is the responsibility of the PARENT to ensure the student brings a current EPI-PEN to school each day.***

_____ _____

Parent Name Parent Signature Date

Revised nld/RN 5/04