



**AGREEMENT FOR STUDENT TO CARRY AND/OR SELF-ADMINISTER PRESCRIPTION
AUTO-INJECTABLE EPINEPHRINE (EpiPen/Twinject/Adrenaclick) AT SCHOOL**

Student Name: _____ **Date of Birth:** _____

School: _____ **Grade:** _____

Please initial each statement below:

Physician Initials	Parent / Guardian Initials	Student Initials	Agreement
_____	_____	_____	1. The student knows the signs and symptoms of an allergic reaction and is able to use an EpiPen/Twinject/Adrenaclick.
_____	_____	_____	2. The student understands that epinephrine (EpiPen/Twinject/Adrenaclick) is a short-acting rescue medication and that additional emergency medical care is necessary. Notify a staff member immediately and Call 911.
_____	_____	_____	3. The physician and parent/guardian(s) believe that the student’s health and welfare is dependent on taking the medication quickly when needed and that going to the health office or finding a classroom staff person may not be adequate.
_____	_____	_____	4. The parent/guardian(s) will supply up-to-date (unexpired) medication as ordered by the physician. They will also immediately inform the School Nurse or Designated Staff at the school of any changes in the physician’s order or medication.
_____	_____	_____	5. The student will keep the EpiPen/Twinject/Adrenaclick on his/her person at all times. If no EpiPen/Twinject/Adrenaclick is available, and an allergic reaction occurs, school staff will call 911.
_____	_____	_____	6. A back-up EpiPen/Twinject/Adrenaclick will be prescribed, sent to school and kept in the health office. If no EpiPen/Twinject/Adrenaclick is available, and an allergic reaction occurs, school staff will call 911.
_____	_____	_____	7. The parent/guardian(s), physician and student understand that the student may be subject to disciplinary action if the EpiPen/Twinject/Adrenaclick is used in a manner other than as prescribed. (If the student does not adhere to this agreement, he or she will lose the privilege of carrying and self-administering the medication.) It is understood that this is for the student’s protection and for the protection of other students at school.

Physician’s Name _____ **Signature** _____ **Date** _____
Type or Print

Parent/Guardian Name _____ **Signature** _____ **Date** _____
Type or Print

Student’s Signature _____ **Date** _____