**Allergy Self Carry Contract** **School:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Grade**: \_\_\_\_\_\_\_

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| **STUDENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| 🞐 I plan to keep my epinephrine with me at school rather than in the school health office.  🞐 I agree to use my epinephrine in a responsible manner, in accordance with my physician’s  orders.  🞐 I will notify the school health office immediately if my epinephrine has been used.  🞐 I will not allow any other person to use my epinephrine.  Student’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| **PARENT/GUARDIAN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| This contract is in effect for the current school year unless revoked by the physician or the student fails to meet the above safety contingencies.  🞐 I agree to see that my child carries his/her medication as prescribed, that the device  contains medication, and that the medication has not expired.  🞐 It has been recommended to me that a back-up epinephrine be provided to the Health  Office for emergencies.  🞐 I will review the status of the student’s allergy with the student on a regular basis as  agreed in the health care plan.  🞐 I will provide the school a signed medication authorization for this medication.  **Parent’s Signature** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| **Nurse Consultant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| 🞐 The above student has demonstrated correct technique for epinephrine use, an   understanding of the physician order for emergency use of the epinephrine.  🞐 School staff that have the need to know about the student’s condition and the need to  carry medication have been notified.  🞐 I will review the medication authorization provided by the parent and signed by the parent  and health care provider.  **Nurse Consultant’s Signature** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

School Administrator’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Teacher’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Teacher’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Assistant Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_