**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| Este contrato estará en efecto el presente año escolar a menos que el doctor del estudiante lo revoque o que el estudiante falle en cumplir las contingencias propuestas en el párrafo anterior.  🞐 Estoy de acuerdo en ver que mi niño/a lleve la medicación prescripta, que el dispositivo  contenga medicina, y que este al día.  🞐 Se me ha recomendado que un epinefrina de emergencia sea provisto al Oficial de Salud  para casos de emergencia.  🞐 Revisaré el estado de las alergias del estudiante regularmente como fue aceptado en el  plan de salud.  🞐 Proveeré a la escuela la autorización firmada por el proveedor de salud autorizando el uso  de la medicación.  **Firma del padre** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Fecha** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_