



## SELF-CARRY AND SELF-ADMINISTRATION OF EPIPEN AND/OR INHALER

### Student Agreement

**I agree to:**

- Follow my licensed healthcare provider’s medication administrations instructions according to the current medication authorization and health care plan(s).
- Use the correct medication administration technique (after return demonstration is approved by school nurse).
- Not allow anyone else to use my medication(s).
- Keep my pharmacy labeled EpiPen and/or Inhaler with me during regular school hours.
- Inform my parent/guardian when I am close to running out of medication or the EpiPen/Inhaler is close to the expiration date on the label.
- Notify my school nurse and school staff if the following occur:
  - My symptoms continue or get worse after taking the medication.
  - My symptoms reoccur during the same school day.
  - I suspect that I am experiencing side effects from my medication.
  - I’ve used my EpiPen due to an allergic reaction.
  - Other \_\_\_\_\_
- I am knowledgeable about my prescribed medicine’s proper use and the side effects.
- I understand that permission to self-carry and self-administer my EpiPen/Inhaler is designed to enhance my self-care skills as I move toward increased independence.
- I understand that permission for possession and self-administration of my EpiPen/Inhaler will be re-evaluated if I am unable to abide by the listed criteria above.

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print name of Student

**I have read and concur with the above student agreement.**

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print name of Parent/Guardian

**The student has demonstrated knowledge about and proper use of his/her emergency medications.**

\_\_\_\_\_  
Signature of School Nurse

\_\_\_\_\_  
Date