THOMAS MACLAREN SCHOOL

CONTRACT FOR STUDENTS CARRYING EPI-PEN®/ ADRENACLICK/AUVI-Q WHILE AT SCHOOL

Student Name _____ Grade" _____

Date of Birth: _____ Name of Medication: _____

Life Threatening Allergy to: _____

If more than one dose is ordered, length of time between dosages of meds to be self-administered: _____

Special instructions/side effects: _____

PHYSICIAN

Physician:

- This student has demonstrated the proper use of the Epi-Pen®/Adrenaclick/Auvi-Q.
- I have instructed the student in the correct and responsible use of the medication.
- I confirm that the student is capable of administering the prescribed medications.

Physician Signature _____ Date _____

Office Phone: _____

PARENT / GUARDIAN

Parent/Guardian:

- My child has demonstrated the proper use of his/her Epi-Pen®/Adrenaclik/Auvi-Q in my presence.
- My child understands his/her allergies, symptoms, and how to properly treat them..
- I give permission for my student to keep his/her Epi-Pen®/Adrenaclik/Auvi-Q with him/her and to self-administer this medication in the school setting.
- I agree to bring an extra (back-up) Epi-Pen®/Adrenaclik/Auvi-Q to be kept in the school health offices.
- I agree to be responsible for ensuring that both the Epi-Pen®/Adrenaclick/Auvi-Q my student carries and the back-up Epi-Pen®/Adrenaclick/Auvi-Q in the school health offices have medication in them and not expired.
- I agree to regularly review with my child the proper use of his/her Epi-Pen®/Adrenaclick/Auvi-Q to include frequency of use, procedure, and documentation of usage when at school.
- I agree that Thomas MacLaren school , school employee, or school nurse is not liable for damages if there is an act of omission related to my child's use of his/her medication unless the damages were caused by the willful or wanton misconduct or disregard of the criteria of the treatment plan.

Parent Signature _____ Date _____

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STUDENT

Student:

- I agree to use my Epi-Pen®/Adrenaclick/Auvi-Q as prescribed by my doctor above. I understand my allergies, symptoms, and treatment plan.
- I agree to keep my Epi-Pen®/Adrenaclick/Auvi-Q with me at school as well as an extra one in the school health offices.
- I agree to notify the health office immediately if I administer my Epi-Pen®/Adrenaclick/Auvi-Q while at school.
- I agree never to share my Epi-Pen®/Adrenaclick/Auvi-Q with anyone.
- I understand that the freedom to manage my Epi-Pen®/Adrenaclick/Auvi-Q independently is a privilege and I agree to abide by the contract.

Student Signature _____ Date _____

SCHOOL NURSE

School Nurse

- I agree to notify staff that have the "need to know" about this student's condition and the need to carry an Epi-Pen®/Adrenaclick/Auvi-Q-

Nurse signature:_____ Date _____

**This Health Plan and any nurse delegation related to this plan are for use during normal operation school hours. After hours, call parent(s) and/or 911 for all medical concerns/emergencies.