PARENT / STUDENT AGREEMENT TO CARRY MEDICATION

This form must be signed after the AUTHORIZATION FOR THE SELF-ADMINISTRATION OF MEDICATION Physician Prescription/Parent Permission form is completed. (This form is only for students carrying an asthma rescue inhaler and/or Epi-Pen)

I, __________________________________________, give permission for my child__________________________________________

Parent/Guardian’s Name Printed Child’s name

to carry the medication described below. I understand that he/she must follow the rules listed below. I will be responsible to notify the school of changes in my child’s medication and provide the proper documentation from the physician.

Name of Medication Dose Frequency of Use

1. __________________________ __________________________ __________________________

2. __________________________ __________________________ __________________________

Parent/Guardian Signature: __________________________ Date __________________________

I, __________________________________________, student at __________________________

Student Name Printed Name of School

agree to the following:

1. I have demonstrated the correct use of the inhaler and/or Epi-Pen to my physician and my school nurse.
2. I agree to never share the inhaler and/or Epi-Pen with another person.
3. I agree that after using the Epi-Pen, I will notify a teacher or other responsible adult who will seek further medical intervention by contacting the school nurse and/or calling 911.
4. I agree that if there is not marked improvement after using my inhaler as directed, I will notify a teacher or other responsible adult who will seek further medical intervention by contacting the school nurse and/or call 911.

Student Signature: __________________________ Date __________________________

If you have any questions, please call your child’s school nurse at:
(847) __________________________

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