ACADEMY DISTRICT 20 CONTRACT TO SELF
CARRY **EPIPENS/TWINJECT**

This contract is in effect for the current school year only unless revoked by the parent, physician, or school nurse or if the student fails to comply with this contract.

All items must be checked and **all** signatures must be present in order for student to have permission to carry their Epipen/Twinject with them while at school.

Student Name_____ Date of Birth _____
Grade _____ Teacher _____
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

____ This student has demonstrated the proper use of the Epipen/Twinject in my office.
____ I have instructed the student in the correct and responsible use of the medication.
____ I confirm that the student has been instructed and is capable of self administering the prescribed medications.

Physician signature _____Date _____

Office Phone:_____

PARENT

____ My student has demonstrated the proper use of his Epipen/Twinject in my presence.
____ My student understands his allergies and knows his symptoms and how to properly treat them.
____ I give permission for my student to keep his Epipen/Twinject with him and to self-administer this medication in the school setting.
____ I agree to bring an extra (back-up) Epipen/Twinject to be kept in the health room.
____ I agree to be responsible for seeing that the Epipen/Twinject my student carries with him and has in the health office have medication in them and are not expired.
____ I agree to regularly review with my student the status of his allergy and the proper use of the Epipen/Twinject.
____ I agree that the school district or school employee is not liable for damages if there is an act or omission related to my student's use of their medication unless the damages were caused by willful or wanton conduct or disregard of the criteria of the treatment plan.

Parent signature _____ Date _____

(OVER)

STUDENT

____ I agree to use my Epipen/Twinject as prescribed by my doctor above. I understand my allergy, symptoms, and treatment plan.
____ I agree to keep my Epipen/Twinject with me at school as well as an extra one in the health room.
____ I agree to notify the school office **immediately** if I administer my Epipen/Twinject.
____ I agree to never share my Epipen/Twinject with any one.

Student signature _____ Date _____

SCHOOL NURSE

____ I agree to notify school staff that have the "need to know" about this student's condition and the need to carry an Epipen/Twinject.

School Nurse signature_____ Date _____

****This Health Plan and any Nurse delegation related to this plan are for use during normal operational school hours****