Medication Agreement for Allergy Treatment

Please return to ______________________________ **Fax:**____________________
School

Name:____________________________________ **DOB**______________ **ID #**___________

Medication______________________________
Dose______________________Route________
Frequency______________________________
Medication used for_______________________
Side Effects____________________________

Medication______________________________
Dose____________________Route_________
Frequency______________________________
Medication used for_______________________
Side Effects____________________________

Printed Name of Prescribing Practitioner:______________________________________

□ This order is effective for the period from ____________________ to ____________________
Month / Day / Year Month / Day / Year

□ The student has been instructed by me or a member of my staff when & how to use his/her EpiPen.

□ This student is capable of self administration of anaphylaxis treatment.

□ This student **is not able** to carry his/her allergy medication.

Prescribing Practitioner Signature____________________________**Date**___________

It is agreed and understood that this medication will be provided by the parent/guardian and may be self administered by student when necessary, to treat the identified symptoms or condition.

If the parent/guardian chooses to have the medication kept locked in the health office and dispensed by the school nurse or trained school designee as per the orders noted above, they release and hold harmless PSD, the school nurse or trained school designee of any claim, demand or action associated with the administration or failure to administer the medication.

Parent:

□ By checking this box: I request my child's allergy medication be kept and administered in the school health office.

□ By checking this box:
1. I agree to see that my child carries the allergy medication that I prescribed.
2. It has been recommended that back up allergy medication / EpiPen be provided to the health office for emergencies.
3. I will agree to notify the school if there are any changes to the treatment plan.

□ By checking this box: I give permission for the school staff to contact the prescribing health care provider regarding this medication and/or health condition.

Parent / Guardian Signature **Date**

Contract for Students Carrying EpiPens With Them While At School

Name:________________________________**DOB:**______________**ID:**__________

STUDENT

- ◻ I plan to keep my allergy medication / Epipen with me at school rather than in the school health office.
- ◻ I agree to use my Epipen in a responsible manner, according to my physician's orders.
- ◻ I will not allow any other person to use my allergy medication / EpiPen.
- ◻ I will notify the school health office immediately if my EpiPen has been used.

Student Signature____**Date**____________

SCHOOL NURSE

- ◻ The above student has demonstrated correct technique for EpiPen use and an understanding of the physician order for emergency use of the EpiPen.
- ◻ School staff that have the need to know about the student's condition and the need to carry medication have been notified.
- ◻ The above student, to the best of my knowledge, is capable of self administering the allergy medication / EpiPen per the health care action plan.
- ◻ I do not feel the above student is capable of self administration and the parent has been notified.

Nurse Signature____**Date**______________