Asthma Self Carry Contract **School: _____Grade: _____**

STUDENT :_____ DOB:_____

☐ I plan to keep my rescue inhaler with me at school rather than in the school health office.

☐ I agree to use my rescue inhaler in a responsible manner, in accordance with my physician's orders.

☐ I will notify the school health office if I am having more difficulty than usual with my asthma.

☐ I will not allow any other person to use my inhaler.

Student's Signature _____Date _____

PARENT/GUARDIAN:_____

This contract is in effect for the current school year unless revoked by the physician or the student fails to meet the above safety contingencies.

☐ I agree to see that my child carries his/her medication as prescribed, that the device contains medication, and the date is current.

☐ It has been recommended to me that a back-up rescue inhaler be provided to the Health Office for emergencies.

☐ I will review the status of the student's asthma with the student on a regular basis as agreed in the health care plan.

☐ I will provide the school a Health Care Provider signed medication authorization for this medication.

Parent's Signature _____Date _____

Nurse Consultant _____ School_____

☐ The above student has demonstrated correct technique for inhaler use, an understanding of the physician order for time and dosages, and an understanding of the concept of pretreatment with an inhaler prior to exercise.

☐ School staff that have the need to know about the student's condition and the need to carry medication have been notified.

☐ I will review the medication authorization provided by the parent and signed by the health care provider.

Nurse Consultant's Signature _____Date _____

School Administrator's Signature: _____ Date: _____
Teacher's Signature: _____ Date: _____
Teacher's Signature: _____ Date: _____
Health Assistant Signature: _____ Date: _____

Allergy Self Carry Contract **School: _____Grade: _____**

STUDENT :_____ DOB:_____

- ☐ I plan to keep my Epi-pen with me at school rather than in the school health office.
- ☐ I agree to use my Epi-pen in a responsible manner, in accordance with my physician's orders.
- ☐ I will notify the school health office immediately if my Epi-pen has been used.
- ☐ I will not allow any other person to use my Epi-pen.

Student's Signature _____Date _____

PARENT/GUARDIAN:_____

This contract is in effect for the current school year unless revoked by the physician or the student fails to meet the above safety contingencies.

- ☐ I agree to see that my child carries his/her medication as prescribed, that the device contains medication, and that the medication has not expired.
- ☐ It has been recommended to me that a back-up Epi-pen be provided to the Health Office for emergencies.
- ☐ I will review the status of the student's allergy with the student on a regular basis as agreed in the health care plan.
- ☐ I will provide the school a signed medication authorization for this medication.

Guardian's Signature _____Date _____

Nurse Consultant _____ School_____

- ☐ The above student has demonstrated correct technique for Epi-pen use, an understanding of the physician order for emergency use of the Epi-pen .
- ☐ School staff that have the need to know about the student's condition and the need to carry medication have been notified.
- ☐ I will review the medication authorization provided by the parent and signed by the parent and health care provider.

Nurse Consultant's Signature _____Date _____

School Administrator's Signature: _____ Date: _____
Teacher's Signature: _____ Date: _____
Teacher's Signature: _____ Date: _____
Health Assistant Signature: _____ Date: _____