



**Individualized Health Plan for Students to Carry Emergency Medications
(Epi-Pen and/or Albuterol Inhaler)**

Student: _____ DOB: _____ Grade/School Year: _____

Medication(s)/Dosage: _____

Emergency Contact Information: _____
(Name & Number)

This agreement allows the authorization for the student to possess the above medication on student's person and administer while in school, on school grounds, or during any school sponsored activity or event.

Student can safely administer above medication if needed

Physician approval for self-administration at school: _____ Date: _____

Student
<input type="checkbox"/> I agree to keep the medication in a secure location. <input type="checkbox"/> I will not allow any other person/student to use my medication. <input type="checkbox"/> I will try to administer medication in the nurse or trainers office unless it is an emergency. <input type="checkbox"/> I plan to keep my medication with me in _____. <input type="checkbox"/> I agree to abide to this health plan. Student's Signature: _____ Date: _____

Parent/Guardian
<input type="checkbox"/> I agree that my child can self-administer the above medication and can recognize when he/she needs to seek the help of a staff member. <input type="checkbox"/> It has been recommended to me that back up supplies be provided to the nurse office in the event of an emergency. <input type="checkbox"/> I understand that this contract is in effect for the current school year and will need to be renewed next year. Parent/Guardian's Signature: _____ Date: _____

School Nurse and/or Athletic Trainer
<input type="checkbox"/> School staff members that have the need to know about the student's condition and the need to carry their medication(s) have been notified. School Nurse/Athletic Trainer's Signature: _____ Date: _____