BETHALTO SCHOOL HEALTH SERVICES CUSD #8

Student Agreement to Carry Epi-pen

1. Student has demonstrated the correct use of Epi-pen to the health care provider and school health personnel.
2. Student agrees to **never** share the Epi-pen with another person.
3. If Epi-pen, student agrees to inform teacher or other responsible adult who will seek further medical intervention as outlined in the student's Allergy Action Plan/or call 911.

Student signature ________________________________Date: ______________________

I give permission for my child, ____________________________, to carry the Epi-pen described below. I understand that he/ she must follow the rules listed above. I will notify the school of any changes in medication (with a note from the physician) or my child's condition.

I further acknowledge that I have been informed, in writing, that the school shall not be liable for self-administration of medication by the student.

NAME OF MEDICATION	DOSE	FREQUENCY OF USE

Parent/ Guardian Signature: ________________________________Date: ____________

Telephone: ________________________Emergency Telephone: ____________________