ARCOLA CUSD #306

CONTRACT FOR SELF-ADMINISTRATION OF Epi Pen

PHONE: 217-268-4961 FAX: 217-268-4719

STUDENT'S NAME: _____

GRADE: _____ DATE OF BIRTH: _____

The following section is to be completed by the **STUDENT**:

I agree to never share my Epi Pen with another person and I will use it only as prescribed and instructed by my doctor. I will tell the teacher, school nurse, or other responsible adult if I need to use it or have used it or if I have any allergy related symptoms.

_____ _____
Student Signature *Date*

The following section is to be completed by the **PARENT**:

I give my permission for _____
to carry an Epi Pen and self-administer the medication as described below. I understand that self- administer means that he/she has the discretion as to the use of the medication. By signing below I authorize the Arcola School District and its employees and agents to allow my child or ward to possess and use his/her Epi Pen while in school, at a school sponsored activity, and before or after normal school activities. The Arcola School District and its employees and agents incur no liability as a result of an injury arising from a student's self-administration of medication. I agree to indemnify and hold harmless the Arcola School District and its employee and agents against any claims arising out of the self-administration of medication by my child. (Legal reference 105 ILCS 5/22-30). I give my permission for the school to contact the physician by telephone, fax, or in writing when necessary in regards to the medication.

_____ _____
Student Signature *Date*

The following section is to be completed by the PHYSICIAN:

NAME OF MEDICATION:_____

DOSAGE: _____ INSTRUCTIONS FOR USE: _____

DIAGNOSIS in which medication is intended: _____

SPECIAL INSTRUCTIONS: _____

I certify that the above name student has been instructed in the use of self-administration of the above named medication. He/she understands the need for medication and necessity to report to school personnel and unusual symptoms regarding he/her allergy. He/she is capable of carrying and using this medication independently.

_____ _____ _____ _____
Physician Signature *Date* *Phone* *Fax*