

# PERMISSION TO CARRY EPIPEN MEDICINE TO SCHOOL CONTRACT.

Please complete and return if you would like your child to carry their EPIPEN medications to school.  
After completing the form, please return to the school clinic.

## STUDENT:

I agree to use my EPIPEN responsibly for my own personal use as directed by my health care provider.  
I have been instructed in the use of this medicine and will follow my health care provider's directions.  
I will not share my medicine with any other person.

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date

## PARENT:

I agree that \_\_\_\_\_ (student's name) has been instructed on when and how to appropriately use their EPIPEN and is able to do so at school.  
I believe my child is responsible to self-medicate at school. I understand a label must be placed on the medication that includes the student's name and a copy of the current dosage and prescription.

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

## PHYSICIAN:

I agree that \_\_\_\_\_ (patient's name) has been instructed on when and how to appropriately use their EPIPEN and is able to do so at school.

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date