



**CONTRACT BETWEEN STUDENT, PARENT, NURSE AND PHYSICIAN FOR  
PERMISSION TO CARRY AND ADMINISTER EPIPEN**

Student name: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date \_\_\_\_\_

1. Student has demonstrated understanding of:
  - a. circumstances of his/her specific allergy
  - b. symptoms of severe reaction or anaphylaxis and identify the need for epinephrine
  - c. techniques of self-administration of Epi Pen
2. Student agrees to never share the Epi Pen with another person.
3. Student agrees to seek help IMMEDIATELY from the school nurse or another adult in the event of exposure to a known allergen (regardless of whether or not epinephrine was self-administered)

I give permission for my child, \_\_\_\_\_ to carry and self-administer epinephrine in the form of Epi Pen or Epi Pen Jr. delivery system. I agree with and understand that she must follow the rules listed above. In the event that, epinephrine needs to be administered, I understand that the Emergency Medical System will be called, and my child will be transported to the nearest available hospital for continued medical support. I will notify the school of any changes in my child's medication or medical condition.

---

Parent/Guardian Signature

Date

---

Physician Signature

Date

---

Physician's name printed

Date