

**Self-Administration Self-Carry of Emergency Medication
Student and/or Parent Agreement
Asthma and Severe Life-Threatening Allergy**

Add school Name or logo here

Name: _____	Grade: _____
DOB: _____	
Emergency Medication: _____	Date: _____

I agree to:

- Follow my prescribing health professional's medication order
- Use correct medication administration technique
- Make a note of when I use medication at school
- Not allow anyone else to use my medication under any circumstances
- Keep a non-expired supply of my medication with me in school and on field trips

Notify the school nurse or school health paraprofessional if the following occurs:

- My symptoms continue or get worse after taking the medication
 - My symptoms reoccur within 2-3 hours after taking the medication for asthma
 - I think I might be experiencing side effects from my medication
 - You think you have used all your medication.
 - Other
- _____

I understand if the inability to fulfill the above criteria is observed, your parent or guardian and health care provider will be contacted to make arrangements for safe access and use of medications.

Signature of Student

Date

The school (including its employees and agents) is to incur no liability as a result of any injury arising from such self-administration of medication. The parent or guardian will indemnify and hold harmless the school (including its employees and agents) against any claim arising out of such self-administration of medication.

Signature of Parent

Date

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