Edgerton District #581 Schools

Health Related Services – 507-442-7881

Self- Administration of Epi-Pen Student Agreement

Name _____ Grade _____

Medication used _____Date _____

I agree to:

- Follow my prescribing health professional's medication orders.
- Tell someone to call 911 when I use my Epi-Pen.
- Use correct medication administration technique.
- Not allow anyone else to use my medication under any circumstances.
- Keep a supply of my medication with me in school and on field trips.
- Ask someone to notify the school nurse or a school employee.
- I understand that permission for self-administration of medication may be discontinued if I am unable to follow the safeguards established above.

_____ _____

Signature of Student Date

○ Verbalizes and demonstrates appropriate use of Epi-Pen

○ Verbalizes known response to allergens and importance of immediate action.

The student has demonstrated knowledge about allergies and use of Epi-Pen.

_____ _____

Signature of School Nurse Date

*copy for school and parent