SAMPLE

Self-Administration of Emergency Medication:
Autoinjectable Epinephrine Autoinjector
Student Agreement

Name: __________________________ Grade: ______

Medication: Epinephrine Autoinjector Date: ______

I agree to:
• Follow my prescribing health professional’s medication order.
• Use correct medication administration technique.
• Not allow anyone else to use my medication under any circumstances.
• Keep the medication with me at all times.
• Let someone know, if possible, when I need to take the epinephrine or immediately after taking it.
  o Someone needs to call 911 right away.
  o An adult needs to be informed of what is happening and the school nurse needs to be contacted if during the school day.
• The school nurse will:
  o Call 911 and arrange transportation to Emergency room. (Injected epinephrine only lasts 20-30 minutes.)
  o Contact Parent/Guardian/Relative Caregiver.
  o Stay with student. Keep student quiet, monitor symptoms, until paramedics arrive.
  o Observe for severe allergic reaction, hives, wheezing, difficulty breathing, swelling (face, neck), tingling/swelling of tongue, vomiting, signs of shock, loss of consciousness.
  o Other __________________________
• I understand that permission for self-administration of medication may be discontinued if am unable to follow the safeguards established above.

____________________________________________  ______
Signature of Student Date

____________________________________________  ______
Signature of Parent/Guardian/Relative Caregiver Date

☐ Student verbalizes Dose __________________________
☐ Student Demonstrates proper Technique
☐ Student verbalizes symptoms/signs of when medication is needed & when to notify school nurse
☐ Student verbalizes Safe Use
☐ Parent and licensed healthcare provider permission to self-administer

The student has demonstrated knowledge about the proper use of his/her medication.

____________________________________________  ______
Signature of School Nurse Date

Modified from School Health Alert 2010