

**I.T.M. Wellness Clinic  
Self-Administration Emergency Medication  
Student Agreement**

Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Grade: \_\_\_\_\_ Sex: \_\_\_\_\_

Name of Medication: \_\_\_\_\_ H.R. Teacher: \_\_\_\_\_

**I agree to:**

- Follow my prescribing health professional's medication orders.
- 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.
- Notify the teacher, school nurse, principal or office clerk if the following occurs:
  - \* I think I might be experiencing an allergic reaction
  - \* Other \_\_\_\_\_
  
- I understand that permission for carrying/ self-administration medication may be discontinued if I am unable to follow the safeguards established above.

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

\_\_\_\_\_  
Date

**\_ Verbalizes Dose \_\_\_\_\_**

**\_ Verbalizes Allergic Reaction Symptoms:**

- Shortness of breath, wheezing, cough
- Swelling of lips, tongue, or around eyes
- Difficulty swallowing or speaking
- Chest tightness, fast heart rate
- Sweating, itching
- Nausea, vomiting, diarrhea, involuntary urination
- Abdominal pain, cramps, or distention
- Bluish discoloration of lips and nail beds
- Anxiety, feeling of impending doom
- Dizziness, passing out, Low Blood Pressure

**\_ Verbalizes Procedure for Safe Usage of his/her EpiPen**

The student **has/has not** demonstrated and verbalized adequate knowledge on the proper use of his/her emergency medication.

\_\_\_\_\_  
Signature of Nurse

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time