

Waukegan Public Schools
Office of School Health Service

PARENT / STUDENT AGREEMENT TO CARRY MEDICATION

This form must be signed after the AUTHORIZATION FOR THE SELF-ADMINISTRATION OF MEDICATION Physician Prescription/Parent Permission form is completed.
(This form is only for students carrying an asthma rescue inhaler and/or Epi-Pen)

I, _____, give permission for my child _____
Parent/Guardian's Name Printed **Child's name**

to carry the medication described below. I understand that he/she must follow the rules listed below. I will be responsible to notify the school of changes in my child's medication and provide the proper documentation from the physician.

Name of Medication	Dose	Frequency of Use
1. _____	_____	_____
2. _____	_____	_____

Parent/Guardian Signature: _____ **Date** _____

I, _____, student at _____
Student Name Printed **Name of School**

agree to the following:

1. I have demonstrated the correct use of the inhaler and/or Epi-Pen to my physician and my school nurse.
2. I agree to never share the inhaler and/or Epi-pen with another person.
3. I agree that after using the Epi-Pen, I will notify a teacher or other responsible adult who will seek further medical intervention by contacting the school nurse and/or calling 911.
4. I agree that if there is not marked improvement after using my inhaler as directed, I will notify a teacher or other responsible adult who will seek further medical intervention by contacting the school nurse and/or call 911.

Student Signature: _____ **Date** _____

If you have any questions, please call your child's school nurse at:
(847) _____