**Student Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent/Guardian AUTHORIZATIONS: Please mark either number 1. Or Number 2. Please do not mark both.**

**\_\_\_\_\_\_ 1**. I want this allergy plan implemented for my child; I **DO WANT** my child to carry & self-administered an epinephrine auto injector. I agree to release the school district & school personnel from all claims of liability if my child suffers any adverse reactions from self-administration of an auto injector.

**\_\_\_\_\_\_ 2.** I want this plan implemented for my child and I **DO NOT** want my child to self-administer epinephrine.

**\_\_\_\_\_\_3**. It is recommended that back up medication be stored with the schoolin case student forgets or loses auto injector &/or antihistamine. The school district is not responsible or liable if backup medication is not provided to the school and student is without working medication when medication is needed.

**Parent/Guardian Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Student Agreement: Please mark 1.-4.**

**\_\_\_\_\_\_ 1.** I have been trained in the use of my auto injector& allergy medication & understand the signs & symptoms for which they are given

**\_\_\_\_\_\_ 2**. I agree to carry my auto injector with me at all times:

**\_\_\_\_\_\_3**. I will notify a responsible adult (teacher, nurse, coach, office staff, etc.) **IMMEDIATELY** when I use my auto injector (epinephrine).

**\_\_\_\_\_\_4**. I will not share my medication with other students or leave my auto injector unattended and I will not use my allergy medications for any other use than what it is prescribed for.

**Student Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_**