

POSSESSION AND USE OF ASTHMA INHALER, EPI-PENS OR OTHER PRESCRIBED EMERGENCY MEDICATION

School Year: _____ Including Summer Session **School:** _____

This form must be completed fully for a student to possess, self-administer, and/or receive an asthma inhaler, Epi-Pen®/epinephrine auto-injector, or other prescribed emergency medication at school. A new form must be completed each school year, for each new medication, and whenever the medication, dosage, schedule, or procedure changes.

- Prescription medication must be in a properly labeled container.
- Medication must be delivered to and from school according to an arrangement satisfactory to the school.
- The parent/guardian must notify the school in writing of any medication change or discontinuation.

PRESCRIBER'S AUTHORIZATION

Name of Student: _____	Date of Birth: _____
Grade: _____	Condition: _____
Medication Name: _____	Dose: _____
Route: _____	Time/Frequency Required: _____

Procedure for Administering:

Special Instructions, Including Storage and Sterility Requirements:

Medication shall be administered/available from: _____ to: _____

Probable Side Effects:

Adverse Reactions That Should Be Reported to the Physician:

Adverse Reactions for an Unauthorized User:

Procedure if Medication Does Not Produce Expected Relief From Student's Asthma Attack/Allergic Reaction:

Prescriber's Name/Title (Type or Print): _____	Telephone: _____
Address: _____	FAX: _____
Prescriber's Signature: _____	Date: _____

(Original signature or signature stamp ONLY)

PARENT/GUARDIAN AUTHORIZATION

Authorization for Possession and Use of Prescribed Emergency Medication

I/We authorize designated school personnel to administer the prescribed emergency medication, if necessary, according to the prescriber's instructions.

I/We agree to make a satisfactory arrangement for delivery of the medication to and from school.

I/We agree to notify the school in writing if the medication, dosage, schedule, or procedure is changed or eliminated.

I/We understand that a new request form must be submitted each school year and for each new medication.

Parent/Guardian Signature: _____

Date: _____

Home Phone #: _____

Cell Phone #: _____

Work Phone #: _____

Other/Emergency #: _____

SELF CARRY / SELF ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION / APPROVAL

Self carry/self administration of the prescribed emergency medication may be authorized by both the prescriber and parent/guardian. Under this authorization, the student may self-administer the medication only in the presence of two (2) authorized school staff members.

Prescriber's authorization for self carry/self administration:

Prescriber's Signature: _____

Date: _____

Parent/Guardian Signature: _____

Date: _____

FOR SCHOOL USE

Date Received: _____

Received By: _____

Medication Verified: ☐ Yes ☐ No

Container/Label Verified: ☐ Yes ☐ No

School Nurse Notified: ☐ Yes ☐ No

Self-Carry Approval: ☐ Yes ☐ No ☐ N/A

Authorized Staff Member #1: _____

Date: _____

Authorized Staff Member #2: _____

Date: _____

Notes:
