SELF – ADMINISTRATION OF EMERGENCY MEDICATION

INHALER AND/OR EPI-PEN (circle one or both)

Possession of an asthma inhaler for prompt treatment of the student’s asthma or epi-pen for prompt treatment of a life-threatening allergy requires written authorization by the parent/guardian and the Physician.

Student name: ______________________________________________________

SELF – ADMINISTRATION GUIDELINES

1. The authorization form must be signed by the provider

2. Parent/guardian assumes responsibility for granting permission for this student to self-administer emergency medication.

3. Parent/Guardian understands the benefit for the school to be supplied with back-up medication in the event the medication is lost or misplaced

PARENT/GUARDIAN AUTHORIZATION FOR SELF-ADMINISTRATION

☐ Yes  ☐ No

________________________________________________  ____________________
Medication

________________________________________________  ____________________
PARENT/GUARDIAN SIGNATURE  DATE

1. This student has been appropriately instructed regarding self-administration.

2. Plan for General Supervision of Student Self-Administering Medication (Include directions to student on transporting and maintaining medication)

___________________________________________________________________________________________

___________________________________________________________________________________________

___________________________________________________________________________________________

SCHOOL NURSE SIGNATURE  DATE

PARENT/GUARDIAN AUTHORIZATION of SELF ADMINISTRATION NOT APPROVED

I request that the above medication be administered by school personnel ONLY.

________________________________________________  ____________________
PARENT/GUARDIAN SIGNATURE  DATE

Revised: 5/2023 Nurse Cheryl