

Asthma Inhaler and EpiPen* Self-Medication Form

Date: _____ Student Name: _____ Student Grade: _____

Student Date of Birth: _____ Student Program: _____

PHYSICIAN TO FILL OUT THIS PORTION:

Medication Name(s) (and strength, if applicable) (Inhaler and/or EpiPen*) _____

Dosing Instructions: _____

Date Medication administration is to begin: _____ Date to Cease: _____

Adverse reactions that could occur and will be reported to Physician: _____

Procedure CTC staff should follow in the event inhaler or EpiPen* does not produce the expected relief from the student's asthma attack and/or allergic reaction: _____

*(*Please note that in all instances an EpiPen is used, 911 will be called. A back up dose of the EpiPen is required to be located in the Clinic.)*

Other Special Instructions: _____

Physician's Name: _____ Phone: _____

Physician's Office Address: _____

As the medication prescriber, I have determined the student is capable of possessing and has been trained in the proper use of the inhaler/ (and/or) EpiPen.

Physician's Signature: _____ Date: _____

Parent/Guardian Name: _____ Phone: _____

Parent/Guardian Signature: _____

This form should be turned in to the school nurse upon arrival at school.

Parents or physician may fax this form to: (937-325-3990) or email to: brendalovelace@springfieldclarkctc.org