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 if 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 us 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@scctc.org

12/05
4/11