

**PHYSICIAN/PARENT MEDICATION REQUEST FORM**  
**SELF ADMINISTRATION OF ASTHMA INHALER OR EPI-PEN**

School \_\_\_\_\_ Grade \_\_\_\_\_ Homeroom \_\_\_\_\_

\_\_\_\_\_  
(Student's Name)

\_\_\_\_\_  
(Student's Date of Birth)

\_\_\_\_\_  
(Student's Address)

is under my care and should be permitted to carry and self-administer the following medication on school grounds and at school activities under the conditions listed below:

Medication Name: \_\_\_\_\_

Dosage: \_\_\_\_\_

Date administration is to begin: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date administration is to end: \_\_\_\_/\_\_\_\_/\_\_\_\_

Procedures to be followed by school personnel if the medication does not produce the expected relief from symptoms:

\_\_\_\_\_  
\_\_\_\_\_

Adverse reactions that should be reported to the physician:

\_\_\_\_\_  
\_\_\_\_\_

Adverse reactions that may occur to another child, for whom the medication is not prescribed, should such a child receive a dose of the medication:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
(Please Print or Type Physician's Name)

\_\_\_\_\_  
(Phone)

\_\_\_\_\_  
(Physician's Signature)

\_\_\_\_\_  
(Date)

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Parent/Guardian's Name: \_\_\_\_\_  
(Please Print or Type)

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Emergency Contact Person \_\_\_\_\_ Phone \_\_\_\_\_

Parent Signature: \_\_\_\_\_ Date \_\_\_\_\_