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 _____