

RESPIRATORY INHALERS/ EPI-PEN/INSULIN SELF-ADMINISTRATION FORM

Name of Student Name of Physician Name of Medication			Grade/Teacher Physician's Phone Number		
		2			
			Dosage	Time	
Medication must be must have student's		ding to Smith	ville School District	's Medication Polic	y. The medication
OBSERVED	RESPONSI	BILITIES	FOR CARRYIN	NG	
	Understands no Will keep medic Agrees to come wheezing, or is Agrees to come	er timing for ot sharing me cation on per eto Nurses O experiencing to Nurses O	medication use edication with other son ffice if having diffic	ulty with breathing er using inhaler or g high or low blood E ABOVE SPECIFIED	administers Epi-Pen sugar
Student Signature		Date	RN Signature	-	Date
COMMENTS:					
MY CHILD AG ADMINISTRAIF MEDICATION	GREES TO FOLLOW TION OF THIS ME	/ THE DISTRIC DICATION. ACCORDING T		CONCERNING THE H	

Parent/Guardian Signature______ Date_____