

Archbishop Alter High School
940 East David Road
Kettering OH 45429

Medication Administration Form

A NEW FORM MUST BE PROVIDED EACH SCHOOL YEAR

Name of student _____ **Grade/Class** _____

Physician Orders

Diagnosis/Circumstances for use _____

Medication _____ Dosage _____ Time/interval _____ Route _____

Possible Adverse reactions _____

Administration to Begin _____ Administration to End _____

Physician Name _____

Address _____ Telephone Number _____

Physician Signature _____ **Date** _____

Permission to Carry Asthma Inhalers/Epi Pens

Physician Signature _____ **Date** _____

As the parent/guardian of this student, I authorize my child to possess and use an epinephrine autoinjector or inhaler, as prescribed, at the school and at any activity, event, or program sponsored by or in which the school is a participant. I understand that a school employee will immediately requests assistance from an emergency medical provider if epinephrine is administered, or if inhaler fails to relieve symptoms.

Please initial:

_____ I authorize and recommend self-medication by my child for the prescribed epi-pen/inhaler.

_____ I also affirm that he/she has been instructed in the proper self-administration of the medication by his/her attending prescriber.

Medication must be supplied by the student/family and must be in the original container.

Parent/Guardian Signature _____ **Date** _____

