POPE JOHN PAUL II HIGH SCHOOL

Student's Name (Last, First, Middle Initial) _____ Date of Birth _____ Grade _____

PRESCRIPTION MEDICATION ADMINISTRATION DURING SCHOOL HOURS

To Be Filled Out By Physician

Allergies:

Food _____

Drugs _____

***EPI-PEN ONLY*:**

1) Will Student carry an Epi-Pen during school hours?

☐ **Yes** ☐ **No** _____ **M.D. Initials**

2) Is the Student competent to self-administer?

☐ **Yes** ☐ **No** _____ **M.D. Initials**

INHALER ONLY:

1) Asthma or Reactive Airway Disease? ☐ **Yes** ☐ **No**

2) Will student carry an inhaler(s)? ☐ **Yes** ☐ **No**

3) Is student competent to self-administer? ☐ **Yes** _____ **M.D. Initials**

Medications/ Inhaler to be administered during school hours:

Diagnosis	Drug	Dosage	Time(s)
Diagnosis	**Drug**	**Dosage**	**Time(s)**
Diagnosis	**Drug**	**Dosage**	**Time(s)**

_____ _____

Physician's Signature **Phone #**

_____ _____

Physician's Name *(Printed)* **Examination Date**

Return this form to _____, School Nurse

FAX 615-822-6226

Rev 1/11