**Miami Valley Career Technology Center**
**6800 Hoke Rd., Clayton, OH. 45315**
**School Clinic Phone: 937-854-6261, FAX: 937-837-1594**

**ASTHMA INHALER OR EPIPEN MEDICATION FORM: SELF ADMINISTRATION/SELF CARRY**

Student Name:_____Grade/Program_____

Student should/should not (circle appropriate option) be permitted to carry medication on his/her person.

Medication Name:_____

Dosing Instructions:_____

Date Medication administration is to begin:_____

Date Medication administration is to cease:_____

Adverse reactions that should be reported to Physician:_____

Adverse reactions that could occur in an authorized user:_____

Procedure to follow in the event that the medication does not produce the expected result:_____

_____

---

The prescriber has determined that the student has been trained in the proper use of the prescribed medication (Asthma inhaler or Epi-Pen). _____YES _____NO

Physician
Signature:_____Date:_____

Physician
Name:_____Phone:_____

Physician
Address:_____

Custodial Parent/Guardian
Signature:_____Date:_____

Daytime phone number:_____

**A BACK UP DOSE OF THE EPIPEN IS RECOMMENDED FOR THE CLINIC.**

**911(EMERGENCY MEDICAL SERVICES) WILL BE CALLED WITH ADMINISTRATION OF THE EPIPEN.**