MIAMI VALLEY
CAREER TECHNOLOGY CENTER
6800 Hoke Road | Englewood, OH 45315
937-854-6261 | 937-837-1594 fax | www.mvctc.com

Authorization for the Possession and Use of Asthma Inhaler/Other Emergency Medication(s) (Form 5330 F3)
To be completed by a licensed prescriber and parent/guardian

Student Information

Name: _____ MVCTC ID #: _____

Address: _____ City: _____ Zip: _____

Partner School: _____ Program: _____

Medication Information (to be completed by prescriber)

Medication Drug Name: _____

Dosage: _____

Start Date: _____ End Date (if known): _____

☐ **YES** ☐ **NO** – *The prescriber has determined that the student has been trained in the proper use of the prescribed medication (Asthma inhaler)*

☐ **YES** ☐ **NO** – *Should the student be permitted to self-carry the medication*

Expected Response to Medication:

_____

_____

Procedures if medication does NOT provide relief:

_____

_____

Adverse reactions for the student to report:

_____

_____

Adverse reactions if another student uses this medication:

_____

_____

Share any special instructions (if any):

_____

_____

Prescriber Name: _____ Emergency Phone: _____

Address: _____ City: _____ Zip: _____

Prescriber Signature: _____ Date: _____

Parent/Guardian Authorization

☐ I authorize my child to possess and use the above-named inhaler or emergency medication as prescribed.

☐ I understand this form must be on file for my child to carry/use their medication at school or school-related events.

Parent/Guardian Name (Print): _____

Parent/Guardian Phone #: _____ Email: _____

Parent/Guardian Signature: _____ Date: _____

Return this form to the MVCTC School Nurse

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Authorization for the Possession and Use of Epinephrine Autoinjector (Epi-Pen) (Form 5330 F4)

To be completed by a licensed prescriber and parent/guardian

Student Information

Name: _____ MVCTC ID #: _____

Address: _____ City: _____ Zip: _____

Partner School: _____ Program: _____

Medication Information (to be completed by prescriber)

Medication Drug Name in Autoinjector: _____

Dosage: _____

Start Date: _____ End Date (if known): _____

☐ **YES** ☐ **NO** – *Prescriber affirms that the student is capable of possessing and using the autoinjector appropriately and has been trained in its proper use.*

Circumstances for Use:

_____

_____

If the student is unable to self-administer, school personnel should:

_____

_____

If the medication does NOT provide expected relief, school personnel should:

_____

_____

Adverse reactions for the student to report:

_____

_____

Adverse reactions if another student uses this autoinjector:

_____

_____

Share any special instructions (if any):

_____

_____

Prescriber Name: _____ Emergency Phone: _____

Address: _____ City: _____ Zip: _____

Prescriber Signature: _____ Date: _____

Parent/Guardian Authorization

☐ I authorize my child to possess and use the above-named epinephrine autoinjector as prescribed.
☐ I understand this form must be on file for my child to carry/use their medication at school or school-related events.
☐ I understand 911 will be called with administration of an epi-pen.
☐ I understand a backup dose of the epi-pen is recommended for the school clinic.

Parent/Guardian Name (Print): _____

Parent/Guardian Phone #: _____ Email: _____

Parent/Guardian Signature: _____ Date: _____