Berlin Brothersvalley School District

ASTHMA INHALER/EPI-PEN SELF-ADMINISTRATION BY STUDENT

_____ _____ _____

Student Name Grade Date

To self medicate, the student must be able to: (check all that apply)

_____ 1. Respond to and visually recognize his/her name.

_____ 2. Identify his/her medication.

_____ 3. Demonstrate the proper technique for self administering his/her medication.

_____ 4. Sign his/her medication sheet to acknowledge having taken the medication.

_____ 5. Demonstrate cooperative attitude in all aspects of self-administration of medication.

_____ _____ _____

Name of Medication Dosage Frequency

The above named student has demonstrated the ability to self-administer the physician-prescribed anaphylaxis/asthma medication, as indicated by the criteria listed above.

_____ _____

Date Signature (Certified School Nurse)

*As the parent/guardian of above named student, I relieve the School District and its employees of any responsibilities for the benefits or consequences of the above listed medication when it is physician-prescribed and parent/guardian authorized. I further acknowledge that the school bears no responsibility for ensuring that the medication is taken. I am aware that any improper use/sharing of the above named medication will result in the immediate confiscation of the epi-pen/asthma inhaler and loss of privilege to self-administer if the medication policy is violated.

_____ _____

Date Parent/Guardian Signature

*I agree to be solely responsible for my epi-pen/asthma inhaler and to follow the directions for its use as ordered by my physician, as well as the district's medication policy. I am aware that any abuse of this privilege will result in the confiscation of my epi-pen/asthma inhaler.

_____ _____

Date Student's Signature

***Parents and students complete these sections.**