SUMMIT ACADEMY NORTH

AUTHORIZATION FOR THE POSSESSION AND USE OF ASTHMA INHALERS, EPI-PENS, OR PRESCRIBED EMERGENCY MEDICATION
MEDICAL ACTION PLAN

This form must be provided to the School Leader assigned to the building of student attendance. Appropriate school staff should be notified.

Student Name: _____ Date: _____

Address: _____

Authorization is hereby given for the student named above to:

[ ] receive the prescribed medication indicated from the designated school personnel.

[ ] self-administer the prescribed medication as permitted by law.

Medication Name: _____

Dosage: _____

Date the administration is to begin: _____ Date the administration is to cease: _____

Adverse reactions that should be reported to the physician: _____

_____

Adverse reactions for unauthorized user: _____

_____

Procedure to follow in the event that medication does not produce the expected relief from student's asthma attack/allergic reaction: _____

_____

Other special instructions: _____

_____

Any additional information required should be attached to this form.

Physician and parent/guardian names, signature, and emergency phone numbers are required.

Physician Name: _____ Phone: _____

Signature: _____

Parent/guardian Name: _____ Phone: (Home) _____
(Work) _____
(Other) _____

Signature: _____ Date: _____

Received by: _____ Date: _____
School Leader

Received by: _____ Date: _____
Office