Self Administration and/or carrying of inhaler, epipen or other anaphylaxis preventative and diabetic supplies

Date: __________

I give my permission to the Milton Middle/High School Nurses to exchange information with ____________________________

Physician’s name and phone number

Concerning medication issues for ________________________________. I also give my

Name of student

Permission for the medication listed below to be administered at school.

Signature of parent or guardian: __________________________________________

Medication ____________________________________________________________

Medication name, dose, time of administration

Reason for giving ______________________________________________________

Beginning date _____________________________ Ending date ________________

Signature of physician ________________________________________________

For students in grades 7-12+

_________________________ has been instructed on the proper use of his/her

Name of student

medication, and may self-administer the following __ inhaler __ epipen __ benadryl

__ insulin, other diabetic supplies. He/She may carry their medication with him/her

in a backpack or other personal carrying bag (inaccessible to other students).

Signature of Physician _____________________________ Date: ______________

Signature of Parent _____________________________ Date: ______________

No medication will be given at school until the school receives this completed form

with the prescribed medication in a container appropriately labeled by the pharmacy or physician. All medication brought to school must be kept in the health office during school hours (unless documented permission by both parties above).

Date received _______________ Signature of School Nurse _________________