POMONA UNIFIED SCHOOL DISTRICT
HEALTH SERVICES & PROGRAMS
Physician's Annual Statement Regarding Administration of Inhaler and/or Auto-Injectable Epinephrine Medication to Student

Student Name: _____ **Date of Birth:** _____

Address: _____ **Phone:** _____

School: _____ **Grade:** _____

To The Health Provider:
Please complete this form if an inhaler and/or auto-injectable epinephrine medication (AIEM) are prescribed for student use during school hours. California Education Code Section 49423.1 authorizes a student to be assisted by the school nurse or other school designated personnel. The student's physician at his or her discretion may also allow a student to carry and self-administer an inhaler and/or AIEM if the physician provides written authorization. **Please submit a new form if there is a change in the dosage, frequency or reason for administration.**

Diagnosis or reason for medication(s): _____

Name of Inhaler: _____ Dosage: _____

Times: _____

Special instructions, precautions or possible side effects: _____

Medication administered until: _____

Name and Dose of Epinephrine: _____

Times: _____

Special instructions, precautions or possible side effects: _____

Medication administered until: _____

CHECK ONE:

_____ **I have instructed this student on the appropriate and safe use of the medication(s) and confirm that this student is able to self-administer the above medication(s).**

_____ **I authorize designated school personnel to administer the above medication(s).**

Signature of Physician: _____ Date: _____ NPI# _____

Print Name of Physician: _____ Phone: _____

Address: _____

To Parent/Guardian: The above medication(s) may be carried by the student and used as prescribed (if authorized by the physician) after this form has been filed with the school health office.