Permit for Self-Medication of Emergency Medication

(To be used for Epi-pens and inhalers **ONLY**)

School year: _____

TO BE COMPLETED BY PHYSICIAN

Student Name: _____ Date: _____

Address: _____

Medication Name: _____

Dosage: _____

Date medication administration is to begin: _____

Date medication 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 the student's symptoms:_____

_____

- I certify this student has been properly instructed on the use of this emergency medication and is allowed to self-carry. The student understands that s/he should never allow anyone else to use this medication.

Physician name: _____ Phone: _____

Physician Signature: _____

Address: 3011 North Union Road, Franklin, OH 45005 Office: 513-423-4542 **Fax: 513-261-6841**

Permit is only valid until end of the current school year