

EMERGENCY MEDICATIONS

Student _____ Date: _____

Date of Birth _____

Allergies _____

Physician(s) _____

Emergency Contact: _____ Relationship _____

Phone Number: _____

Parent/Guardian Signature: _____

_____ Nurse will fill out the area below _____

ASTHMA INHALER

Medication and dosage _____

Administration instructions _____

Stored in: Nurse's office _____ Book bag _____

DIASTAT RECTAL GEL

Medication and dosage _____

Administration instructions _____

Stored in: Nurse's office _____ Book bag _____

EPI PEN

Medication and dosage _____

Administration instructions _____

Stored in: Nurse's office _____ Book bag _____