



**REQUEST FOR SELF-ADMINISTRATION OF MEDICATION AT  
SAN JOAQUIN OUTDOOR SCHOOL**

**(THIS FORM IS ONLY FOR AUTO-INJECTABLE EPINEPHRINE OR INHALED ASTHMA MEDICATION!)**

Student: \_\_\_\_\_ Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Male \_\_\_\_ Female \_\_\_\_

School: \_\_\_\_\_ Teacher: \_\_\_\_\_ Grade: \_\_\_\_\_

**TO BE COMPLETED BY PHYSICIAN**

<u>Medication 1</u>	<u>Medication 2</u>
Health condition: _____	Health condition: _____
Medication name: _____	Medication name: _____
Dose (# mg, ml, puffs, etc.): _____	Dose (# mg, ml, puffs, etc.): _____
Method of Administration: _____	Method of Administration: _____
Duration(s): _____	Duration(s): _____
PRN (prescribed as needed): symptoms _____	PRN (prescribed as needed): symptoms _____
_____	_____
Frequency _____	Frequency _____
____ For episodic/emergency events only	____ For episodic/emergency events only
Special instructions: _____	Special instructions: _____
_____	_____
Restrictions and/or possible side effects	Restrictions and/or possible side effects
____ none anticipated	____ none anticipated
____ yes – please describe: _____	____ yes – please describe: _____
_____	_____
Special storage requirements: ____refrigerate ____none	Special storage requirements: ____refrigerate ____none
This student is both capable and responsible for self-administering auto-injectable epinephrine or inhaled asthma medication. ____ Yes-supervised ____ Yes-unsupervised ____ No	This student is both capable and responsible for self-administering auto-injectable epinephrine or inhaled asthma medication. ____ Yes-supervised ____ Yes-unsupervised ____ No
This student may carry medication: ____ Yes ____ No	This student may carry medication: ____ Yes ____ No

**Physician's signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Phone #** ( ) \_\_\_\_\_ **Address:** \_\_\_\_\_

I, \_\_\_\_\_, certify that the forgoing is true and correct.  
**Physician's Name (print)**

**Attention: SCHOOL NURSE:** Please make sure a copy of the student's "School Inhaler/EpiPen Procedures" from his/her school file must be attached to this form and that they have a photo attached to each of their medication. Thank you!

Reviewed by School Nurse \_\_\_\_\_ Date: \_\_\_\_\_



**PARENT/GUARDIAN CONSENT  
FOR SELF-ADMINISTRATION OF MEDICATION  
RELEASE OF MEDICAL INFORMATION AND RELEASE OF LIABILITY**

I hereby consent for my child, \_\_\_\_\_, to self-administer the following medication during the regular school day or when attending school related activities:

Auto-injectable epinephrine

Inhaled asthma medication

I also consent to disclose identifiable health information by the health care provider to the school nurse or other personnel designated by the San Joaquin County Office of Education/Outdoor Education.

I acknowledge that I have an obligation to notify the outdoor school if my child’s medication, dosage, or frequency of administration or reason for administration changes during the school year.

I, on behalf of myself, my child, our heirs, executors and assigns, hereby agree to hold harmless, release, and covenant not to sue the San Joaquin County Office of Education, its officers, employees, and agents, for any and all liability, claim, or cause of action of any nature whatsoever, including but not limited to personal injury or death, which may result from my child’s self administration of medication.

**Please send two medications, one for the child to carry and one for back-up.**

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Printed Name of Parent/Guardian

\_\_\_\_\_  
Date

“School Inhaler Procedures” form attached

Student’s photo attached to his/her medication (SASI photo acceptable)

Date: \_\_\_\_\_ reviewed by School Nurse      Signature of Nurse: \_\_\_\_\_

Date: \_\_\_\_\_ reviewed Principal      Signature of Principal: \_\_\_\_\_