POTTSGROVE SCHOOL DISTRICT

SELF ADMINISTRATION CHECKLIST FOR MEDICATIONS
(EPI-PENS AND ASTHMA MEDICATION ONLY)

STUDENT NAME_____ **GRADE**_____

☐ 1. Student is able to respond to and visually recognize his/her name.

☐ 2. Student is able to identify his/her labeled medication.

☐ 3. Student is able to demonstrate proper technique for self administration.

☐ 4. **Student understands that after use of Epi-Pen, 911 is to be activated.**

☐ 5. Student verbalizes understanding of **need to report to nurse's office** for documentation and assessment **following self administration of asthma medication.**

☐ 6. Student agrees to demonstrate cooperative attitude in all aspects self administration.

☐ 7. Student will verbalize awareness that inhaler/epi-pen is for his/her use ONLY and may not be shared with other students.

Violations of this policy shall result in immediate confiscation of the medication and loss of privileges as determined by an administrator.

_____ _____
School Nurse Date

_____ _____
Student Date

_____ _____
Parent Date

10/05