

**SUMMIT ACADEMY NORTH**  
**AUTHORIZATION FOR THE POSSESSION AND USE OF ASTHMA INHALERS, EPI-PENS,**  
**OR PRESCRIBED EMERGENCY MEDICATION**  
**MEDICAL ACTION PLAN**

This form must be provided to the School Leader assigned to the building of student attendance. Appropriate school staff should be notified.

Student Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Address: \_\_\_\_\_

Authorization is hereby given for the student named above to:

- receive the prescribed medication indicated from the designated school personnel.
- self-administer the prescribed medication as permitted by law.

Medication Name: \_\_\_\_\_

Dosage: \_\_\_\_\_

Date the administration is to begin: \_\_\_\_\_ Date the 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 student's asthma attack/allergic reaction: \_\_\_\_\_

Other special instructions: \_\_\_\_\_

Any additional information required should be attached to this form.  
Physician and parent/guardian names, signature, and emergency phone numbers are required.

Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Signature: \_\_\_\_\_  
Date \_\_\_\_\_

Parent/guardian Name: \_\_\_\_\_ Phone: (Home) \_\_\_\_\_  
(Work) \_\_\_\_\_  
(Other) \_\_\_\_\_

Signature: \_\_\_\_\_  
Date \_\_\_\_\_

Received by \_\_\_\_\_ Date \_\_\_\_\_  
School Leader

Received by \_\_\_\_\_ Date \_\_\_\_\_  
Office