

**CCSD Medication Checklist**  
**EPI-PEN, INHALERS, GLUCAGON**  
**Nursing and Health Services**



**RN  
Approval**

**STUDENT INFORMATION**

Student:	School:	Grade:	Date:
Medication:	Designated Employee Completing Form:		

**DO NOT TAKE IN OR ADMINISTER ANY MEDICATIONS  
UNTIL ALL OF THE CHECKLIST STEPS ARE COMPLETED**

**INITIAL THE STEPS BELOW AND SIGN WHEN COMPLETED**

Parent Signature on the appropriate form i.e. Allergy, Asthma, DMMO	
Health Care Provider Signature on the appropriate form i.e. Allergy, Asthma, DMMO. <b>SMMO Forms may only be checked in by the RN</b>	
Medication labeled with Student's Name, Medication Name, Dose, Route and Time(s) to be administered	
Write down the number of the injector(s) and/or inhalers(s) that are being checked in	#:
Date the medication was brought to the school in labeled container	Date:
Dosage on medication label matches dosage written on consent form	
Medication appropriately stored as indicated below	
Medication Calendar generated including student information, medication, dosage and inventory	
Medication Calendar has the designated and trained employee signature(s) on the back of the form	

**STORAGE REQUIREMENTS FOR EMERGENCY MEDICATIONS**

**Emergency medications such as Epi-Pens, Glucagon, Insulin, and Asthma Inhalers are to be stored in a secure location that is not readily accessible to other students, but is not required to be kept locked. Seizure rescue medication and all other medications should be stored in a locked box, cabinet or drawer.**

**HEALTH AIDE/SECRETARY SIGNATURE**

Health Aide/Designated Employee Signature:	Date:
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**DISTRICT RN SIGNATURE**

School Nurse Signature:	Date:
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