Tulsa Public Schools

Health Services

Emergency Instructions – Injectable Medications Training Record

Student's
Name:_____Birthdate:_____
School:_____Grade:_____Room:_____
Allergic To:_____

Observe for: (Check all that apply)

___Flushing, itching of skin
___Difficulty in breathing
___Weak, rapid pulse
___Nausea, vomiting, abdominal cramps
___Other(list)_____

Action steps:

1. Notify Parent/Legal Guardian/Person Responsible for Student's Care/or Emergency Contact

_____ _____ _____ _____
Parent/Legal Guardian/Person Responsible For Student's Care/ or Emergency Contact — Home Phone — Work Phone — Cellular Phone

2. Call for Emergency Assistance as indicated: Phone_____
3. Give EMERGENCY MEDICATION as indicated

Medication _____ _____ _____ _____
Instruction: Name of Medication — Dosage — How Given — Where Stored

Medication _____ _____ _____ _____
Instruction: Name of Medication — Dosage — How Given — Where Stored

Medication _____ _____ _____ _____
Instruction: Name of Medication — Dosage — How Given — Where Stored

Other Instructions:_____

Physician or Dentist:_____ Phone:_____
Preferred Hospital:_____ Phone:_____

Training Presented By:_____
Name **Title/Relationship to Student**

BY SIGNING BELOW I ACKNOWLEDGE I HAVE VOLUNTEERED, AT THE REQUEST OF THE PARENT/GUARDIAN/PERSON RESPONSIBLE FOR STUDENT'S CARE, TO RECEIVE TRAINING IN THE ADMINISTRATION OF THE ABOVE LISTED MEDICATION. I WAS TRAINED BY THE PERSON LISTED ABOVE. I AGREE TO ADMINISTER THE ABOVE MEDICATION(S) AS INDICATED IN CASE OF EMERGENCY.

Date of Training	Name of Person Trained	Signature of Person Trained

OVER

Date	Name of Person Trained	Signature of Person Trained

This Request must be renewed each School year.
HD38D 07/94, 11/02