

USE of ASTHMA INHALER

AUTHORIZATION FOR THE POSSESSION AND USE OF ASTHMA INHALERS

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: _____

Other special instructions: _____

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 _____

Copies must be provided to Principal and to the School Nurse if one is assigned to the student's building.