

## 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, signatures and emergency phone numbers are required.**

Physician name: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Parent/guardian name: \_\_\_\_\_ Phone – Home: \_\_\_\_\_

Phone – Work: \_\_\_\_\_

Phone – Cell: \_\_\_\_\_

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

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