AUTHORIZATION FOR THE POSSESSSION AND USE OF ASTHMA INHALER/OTHER EMERGENCY MEDICATION(S)

Student Name: _____ Date _____

Address: _____

Authorization is hereby given for the student named above to:

[ ] receive the prescribed medication indicated from the designated school personnel.

[ ] keep emergency medication in his/her possession.

[ ] 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 ***prescriber;*** _____

_____

Adverse reactions for unauthorized users: _____

_____

Procedure to follow in the event that medication does not produce the expected relief form student's asthma attack or other condition requiring emergency medication: _____

_____

_____

Other special instructions: _____

_____

Prescriber and parent/guardian names, signature and emergency phone numbers are required.

Precriber 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.

Authorization for Staff

The following staff members are authorized to administer the above- prescribed medication(s) / treatment(s):

_____

_____

_____

PRINCIPAL