Jackson-Milton Local Schools

AUTHORIZATION FOR THE POSSESSION 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 user:_____

_____

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

_____

Other special instructions:_____

_____

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

Prescriber name:_____Phone:_____

Prescriber Signature:_____Date:_____

Parent/guardian name:_____Phone: (Home)_____

(Work)_____

(Other)_____

Parent/guardian Signature:_____Date:_____

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