# Arcanum-Butler Local School District
# Self-Medication For Asthma Inhalers

Authorization Form

Student Name:______________________________________________Date:________________

Address:___________________________________

___________________________________

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:

Physician name:______________________________________Phone:___________________

Physician Signature:_____________________________________Date:___________________

Parent/guardian name:___________________________________Phone:(work)_______________

(home)____________________

(other)____________________

Signature:___________________________________________Date:_____________________

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