AUTHORIZATION FOR THE POSSESSION AND USE OF ASTHMA INHALERS, EPI-PENS, OR PRESCRIBED EMERGENCY MEDICATION

This form must be provided to the principal assigned to the building of student attendance. Appropriate school staff should be notified.

Student Name: ___________________________________________ Date: ______________________

Address: _____________________________________________________________

Authorization is hereby given for the student named above to 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: ________________________________

________________________________________________________________________________

Procedure to follow in the event that medication does not produce the expected relief from student’s asthma attack/allergic reaction: __________________________________________________________

________________________________________________________________________________

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 ______________________

Received by ___________________________ Date ___________________________

Principal

Received by ___________________________ Date ___________________________

Office Staff

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