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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