Self-Medication for Asthma Inhalers

School Year: _____ As required by Section 3313.716 Ohio Revised Code

This Section to be completed by Physician

Student Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Medication Name: _____

Please Check One: ☐ Inhaler to be available in office & administered with supervisor

☐ Inhaler to be carried on person

Dosage: _____

Date the administration is to begin: _____ Ends: _____

Adverse reactions that should be reported to the physician: _____

_____

Adverse reactions if used by ***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, Parent/Guardian Names and Emergency Numbers must be completed

Physician Name: _____ Phone: _____

Signature: _____ Date: _____

Please Check One: ☐ Inhaler to be available in office & administered with supervisor

☐ Inhaler to be carried on person

Parent/Guardian Name: _____

Signature: _____ Date: _____

Phone: home: _____ work: _____ cell: _____

Copies of this form must be provided to the principal and to the school nurse *Revised 3/11 (blue)*