

**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 reaction 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: \_\_\_\_\_

Signature: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ (print name) Phone (work): \_\_\_\_\_  
Phone (cell): \_\_\_\_\_

Phone (other): \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

I hereby authorize that the above-named student may carry an asthma inhaler for the sole purpose of self-medication, when necessary. Any unauthorized use of this medication may subject the child to discipline under the Findlay City District's Board Policies.

Principal: \_\_\_\_\_ Date: \_\_\_\_\_

Copies must be provided to Building Principal, Building Nurse, and Director of Transportation, if applicable.