

AUTHORIZATION FOR THE POSSESSION AND USE OF ASTHMA INHALER/OTHER
EMERGENCY MEDICATION(S)

Student Name: _____ Date: _____

Address: _____

Authorization is hereby given for the student named above to:

- receive the prescribed medication indicated from the designated school personnel.
- keep emergency medication in his/her possession.
- 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 prescriber: _____

Adverse reactions for unauthorized user: _____

Procedure to follow in the event that medication does not produce the expected relief from student's asthma attack or other condition requiring emergency medication: _____

Other special instructions: _____

Prescriber and parent/guardian names, signature, and emergency phone numbers are required.

Prescriber name: _____ Phone: _____

Signature: _____ Date: _____

Parent/guardian name: _____ Phone: (Home) _____
(Work) _____
(Other) _____

Signature: _____ Date: _____

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

AUTHORIZATION FOR THE POSSESSION AND USE OF EPINEPHRINE AUTOINJECTOR
(EPI-PEN)

Student Name: _____ Date: _____

Address: _____

Name of Medication in Autoinjector: _____

Dosage: _____

Date the administration is to begin: _____

Date the administration is to cease: _____

Prescriber must acknowledge one of the following (please initial):

The student is capable of possessing and using the autoinjector:	Yes _____	No _____
The student has been trained on the proper use of the autoinjector:	Yes _____	No _____

The autoinjector should be used in the following circumstances: _____

Procedure to follow if student is unable to administer the anaphylaxis medication: _____

Procedure to follow if the medication does not produce the expected relief from the student's anaphylaxis: _____

Adverse reactions that should be reported to the prescriber: _____

Adverse reactions for unauthorized user: _____

Other special instructions: _____

Prescriber and parent/guardian names, signature, and emergency phone numbers are required.

Prescriber Name: _____ Phone: _____

Signature: _____ Date: _____

Parent/Guardian Name: _____ Phone: (Home) _____

(Work) _____

(Other) _____

Signature: _____ Date: _____

Other Emergency Contact Name: _____ Phone: _____

Parent/Guardian (or student if eighteen (18) or over) must acknowledge one (1) of the following (please initial):

The principal or school nurse (if one has been assigned to the student's building) has been provided with a backup dose of the student's medication: Yes _____ No _____

Principal or school nurse must acknowledge one of the following (please initial):

I have received a backup dose of the student's medication: Yes _____ No _____

Copies must be provided to the principal and to the school nurse if one is assigned to the student's building.

4/07