

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

Student Name: _____ DOB _____ Date: _____

Address: _____ School: _____

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: _____

Prescriber Signature: _____ Date: _____

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

Parent Signature: _____ Date: _____

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

10/12/16