AUTHORIZATION FOR THE POSSESSION AND USE OF ASTHMA INHALER/OTHER EMERGENCY MEDICATIONS

Student Name _____ Date _____
Address _____
Authorization is hereby given for the student name 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 end _____

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 the 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 the Principal and to the School Nurse if one is assigned to the student's building.