SELF-MEDICATION FOR ASTHMA INHALERS AUTHORIZATION FORM

Student's Name________________________________ Date__________________

Address____

Dosage____

Name of Medication____

Date the administration is to: Begin________________ End____________________

Adverse reactions that should be reported to physician____________________________

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Adverse reactions for unauthorized user___________________________________

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Procedure to follow in the event that medication does not produce the expected relief from the student's asthma attack ____

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Other special instructions____

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Physician's Name____________________________________ Phone____________

Physician's Signature_________________________________ Date_____________

Parent/Guardian Name_________________________________ Date_____________

Parent/Guardian Signature____

Phone/Work____

Phone/Home____

Other Phone____

COPIES MUST BE PROVIDED TO PRINCIPAL AND SCHOOL NURSE.