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 reactions that should be reported to the physician: _____

_____

Procedures to follow in the event that medication does not produce the expected relief from student's asthma attack: _____

_____

Other special instructions: _____

_____

* * * * * * * * * * * * *

Physician Name: _____ Phone: _____

Signature: _____ Date: _____

Parent/Guardian Name: _____ Phone: (work) _____
(home) _____
(other) _____

Signature: _____ Date: _____

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