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: _____

_____

Adverse reactions for unauthorized user: _____

_____

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

_____

_____

Other special instructions: _____

_____

Physician and parent/guardian names, signatures and emergency phone numbers:

Physician Name: _____ Phone: _____

Signature: _____ Date: _____

Parent/Guardian Name: _____ Phone (work) _____

(home) _____

(other) _____

Signature: _____ Date: _____

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

Compliments of the Ohio Association of School Nurses, P.O. Box 162, Worthington, OH 45305

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