Self-Medication for Asthma Inhalers
Authorization Form

Student Name: ______________________________ Date: ____________________

Address: ______________________________

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Medication Name: ______________________________

Dosage: ______________________________

Date the administration is to begin: ______________________________

Date the administration is to cease: ______________________________

Adverse reactions that should be reported to the 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 student's asthma attack: ______________________________

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Other special instructions: ______________________________

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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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