SELF-MEDICATION FOR ASTHMA INHALERS
AUTHORIZATION FORM

Student _____ Date_____

Address _____ Home Tel _____

City/State/Zip _____

Name of Medication _____

Dosage _____

Date to Begin Administration _____ Date to End Administration _____

Adverse reactions that should be reported to 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 Numbers

Physician Name _____ Tel _____

Signature of Physician _____ Date_____

Parent(s) Name _____ Home Tel _____

Work Tel _____

Other Tel _____

Signature of Parent/Guardian _____ Date_____

Copies must be provided to the principal and to the school nurse.

—adapted from the Ohio Association of School Nurses