

**SELF-MEDICATION FOR ASTHMA INHALERS/EPINEPHRINE AUTOINJECTOR
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 provider: _____

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:

Provider name: _____ Phone: _____

Signature: _____ Date: _____

Parent/guardian name: _____ Phone: (w) _____
(h) _____
(other) _____

Signature: _____ Date: _____

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

Adopted: 10/21/99

Revised: 3/29/07