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 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: (w) _____
(h) _____
(other) _____

Signature: _____ Date: _____

Copies must be provided to the principal and to the school nurse if one is assigned to the student's building.