# SELF-MEDICATION FOR ASTHMA INHALERS

## Authorization Form

Student's Name: _____ 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 Telephone 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*