SELF-MEDICATION FOR ASTHMA INHALERS AUTHORIZATION FORM

Student Name _____ Date _____

Address _____
_____

Medication Name _____

Dosage _____

Date to begin _____ Date to end _____

Adverse reactions that should be reported to the 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 _____
Phones (home) _____ Cell _____

Signature _____ Date _____