AUTHORIZATION FOR THE POSSESSION AND USE OF ASTHMA INHALER/OTHER EMERGENCY MEDICATION(S)

Student Name: ___________________________________________ Date: ____________________

Address: __________________________________________________________________________

Authorization is hereby given for the student named above to:

[ ] receive the prescribed medication indicated from the designated school personnel.
[ ] keep emergency medication in his/her possession.
[ ] self-administer the prescribed medication as permitted by law.

Medication Name: ___________________________________________________________________

Dosage: ___________________________________________________________________________

Date the administration is to begin: _________________________________________________
Date the administration is to cease: ________________________________________________

Adverse reactions that should be reported to the prescriber: ___________________________

Adverse reactions for unauthorized user: _____________________________________________

Procedure to follow in the event that medication does not produce the expected relief from student’s asthma attack or other condition requiring emergency medication: _______________________

Other special instructions: __________________________________________________________

Prescriber and parent/guardian names, signature, and emergency phone numbers are required.

Prescriber name: ___________________________________ Phone: _________________________

Signature: ______________________________________ Date: ___________________________

Parent/guardian name: ___________________________ Phone: (Home) ________________
            (Work) __________________ (Other) __________________

Signature: ______________________________________ Date: _________________________

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

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