

Self-Medication Form for Asthma Inhalers
Authorization Form

Student's Name: _____ Date: _____

Address: _____

Medication Name: _____

Dosage: _____

Start Date: _____ End Date: _____

Adverse reactions that should be reported to the physician: _____

Adverse reactions for unauthorized User: _____

Procedure to follow in the event 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: _____ Phone: (home) _____

(work) _____

(other) _____

Parent Signature: _____ Date: _____

Please return to the School Nurse