

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.

10/03  
12/05