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.

1/06

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