Mifflin Fax 419-589-6659

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.