

SELF-MEDICATION FOR ASTHMA INHALERS

Authorization Form

Student's Name: _____ Date: _____

Address: _____ Home Phone: _____

City/State/Zip: _____

Name of Medication: _____

Dosage: _____

Date to begin administration: _____ Date to end administration: _____

Adverse reactions that should be reported to physician:

Adverse reactions for unauthorized user:

Procedure to follow in the event that medication does not produce the expected relief from student's attack:

Other special instructions:

Physician and Parent/Guardian Names, Signatures, and Emergency Telephone Numbers

Physician Name: _____ Phone: _____

Signature of Physician: _____ Date: _____

Parent(s) Name: _____ Home Phone: _____

Work Phone: _____

Other Phone: _____

Signature of Parent/Guardian: _____ Date: _____