SOUTHWEST LICKING LOCAL SCHOOL DISTRICT
Self-Medication for Asthma Inhalers
Authorization Form

Student name: ____ Date: ________________

Address: ____

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Medication name: ____

Dosage: ____

Date the administration is to begin: ____

Date the administration is to cease: ____

Adverse reactions that should be reported to the physician: ___________________________

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Adverse reactions for unauthorized user: ____

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

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Other special instructions: ____

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Physician and parent/guardian names, signatures, and emergency phone numbers:

Physician name: ________________________________ Phone ______________________

Physician's signature: _____________________________ Date: ______________________

Parent/guardian name: ___________________________ Work phone: ________________
Home phone: ________________
Other: ________________

Parent/guardian signature: ________________________ Date: ______________________

Copies must be provided to principal and to the school nurse if one is assigned to the student's building.

Effective 11/1/99