New Albany Plain Local Schools

Self Medication For Asthma - Inhalers Authorization Form

Student Name: _____ Grade: _____

Address: _____

_____

Medication name: _____

Dosage: _____

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

Adverse reactions that should be reported to the physician: _____

_____

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

_____

_____

Other instructions: _____

_____

By signing below the physician or other health care provider and parent/guardian state that it is their request that the child carry the inhaler on their person at school and at school functions; they realize that because the student is self-administering medication, no adult may be aware that the student is experiencing difficulty, preventing adults from responding appropriately in an emergency; and that the child has been fully trained in the use of the inhaler, knows why, how and when to use it properly and will not give the inhaler to any other students.

Physician name: _____ Phone: _____

Signature: _____ Date: _____

Parent / Guardian name _____ Phone: _____

Signature: _____ Date: _____

In the event that the metered doses inhaler is abused or misused by the student or others, school personnel have the responsibility to assume control of the inhaler and contact the parent/guardian to assess the next best action for the student, classmates and others.

Nurse's signature _____ Date: _____