

SELF-MEDICATION FOR ASTHMA INHALERS/EPINEPHRINE AUTOINJECTOR
AUTHORIZATION FORM

Student Name: _____ Date: _____

Address: _____

Medication Name: _____

Dosage: _____

Date the administration is to begin: _____

Date the administration is to cease: _____

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 asthma attack: _____

Other special instructions: _____

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

Physician name: _____ Phone: _____

Signature: _____ Date: _____

Parent/guardian name: _____ Phone: (w) _____

(h) _____

(other) _____

Signature: _____ Date: _____

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