LICKING HEIGHTS LOCAL SCHOOLS

SELF MEDICATION FOR ASTHMA-INHALERS AUTHORIZATION FORM

Student Name:_____ Grade:_____
Address:_____
Medication Name:_____
Dosage:_____
Date to begin administration:_____Date to end administration:_____
Adverse reactions that should be reported to the physician:_____
_____
Procedure to follow in the event that medication does not produce the expected relief from the student's asthma attack:_____
_____

By signing below the physician or other health care provide 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:_____Phone:_____
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:_____