AUTHORIZATION FOR THE POSSESSION AND USE OF ASTHMA INHALERS, EPI-PENS, OR PRESCRIBED EMERGENCY MEDICATIONS.

This form must be provided to the principal assigned to the building of student attendance. Appropriate school staff should be notified.

Student Name:_____ Date_____

Address: _____

Authorization is hereby given for the student named above to:

- Receive the prescribed medication indicated from the designated school personnel.
- Self-administer the prescribed medication as permitted by law.

Medication Name: _____ Dosage: _____

Date the administration is to begin: _____ Date the administration is to cease:_____

Adverse reactions that should be reported to the 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/allergic reaction: _____

_____

Other special instructions: _____

_____

Any additional information required should be attached to this form.

_____

Physician Name: _____ **Phone:** _____

Signature: _____

Parent/guardian Name: _____ **Phone:** (Home) _____

Signature: _____ **Date** _____ (Work) _____

(Other) _____

Received by Principal_____ **Date:** _____

Received by Nurse_____ **Date:** _____