SELF-MEDICATION FOR ASTHMA INHALERS
Loudonville-Perrysville Schools
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 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:_____

_____

Other special instructions:_____

_____

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

_____
(Physician Name) (Phone No.)

_____
(Physician's Signature) (Date)

Parent/Guardian Name:_____

_____
(Home Phone Number) (Work Phone Number)

_____
(Parent/Guardian Signature) (Date)

Notes:
1. A copy must be provided to the Principal.
2. Inhalers must be labeled with student's name and instructions for use.
3. Permission Void at End of Current School Year