

**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
-