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

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

Student's 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 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:	

Physician and parent/guardian names, signature and emergency phone numbers are required.

Physician Name:		
Physician Telephone:		
Physician Signature:		Date:
Parent/Guardian Name:		
Parent/Guardian Telephone: Home:	Work:	Other:
Parent/Guardian Signature:		Date:
Received by:		Date:
Received by:		Date:

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