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 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:_____

Administration start date:_____ End : _____

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.

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

Physician name:_____ Phone:_____

Signature:_____ Date:_____

Parent/guardian name:_____ Home phone:_____

Work phone:_____

Other phone:_____

Signature:_____ Date:_____

Received by:_____ Date:_____

Principal

Received by:_____ Date:_____

Nurse