

AUTHORIZATION FOR THE POSSESSION AND USE OF ASTHMA INHALERS

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: \_\_\_\_\_

Other special instructions: \_\_\_\_\_

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

Physician name: \_\_\_\_\_ Phone: \_\_\_\_\_

Signature: \_\_\_\_\_ Date \_\_\_\_\_

Parent/guardian name: \_\_\_\_\_ Phone: (Home) \_\_\_\_\_  
(Work) \_\_\_\_\_  
(Other) \_\_\_\_\_

Signature: \_\_\_\_\_ Date \_\_\_\_\_

Received by \_\_\_\_\_ Date \_\_\_\_\_  
Principal

Received by \_\_\_\_\_ Date \_\_\_\_\_  
Nurse

**REVISED FORM – 1ST HALF 2004**

**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: \_\_\_\_\_

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.***

AUTHORIZATION FOR PRESCRIBED MEDICATION OR TREATMENT

To the Parent:

THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT TO USE PRESCRIBED MEDICATIONS OR TO RECEIVE TREATMENT IN SCHOOL. ALL SPACES MUST BE COMPLETED.

\_\_\_\_\_  
Name of Student

\_\_\_\_\_  
Address

\_\_\_\_\_  
School

\_\_\_\_\_  
Grade

- A. I am requesting permission for my child named above to: (Check all that apply)
- use or receive prescribed medication
  - receive prescribed treatment
  - self-administer prescribed medication(s) in my presence or that of an authorized staff member
- in accordance with the Doctor's prescription.
- B. I will assume responsibility for safe delivery of the medication to school.
- C. I will notify the school immediately if there is any change in the use of the medication or the prescribed treatment.
- D. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.

\_\_\_\_\_  
Signature of Parent

\_\_\_\_\_  
Date

\_\_\_\_\_  
Home Telephone

\_\_\_\_\_  
Work Telephone

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

Physician name: \_\_\_\_\_ Phone: \_\_\_\_\_

Signature: \_\_\_\_\_  
Date \_\_\_\_\_

Parent/guardian name: \_\_\_\_\_ Phone: (Home) \_\_\_\_\_  
(Work) \_\_\_\_\_  
(Other) \_\_\_\_\_

Signature: \_\_\_\_\_  
Date \_\_\_\_\_

Received by \_\_\_\_\_ Date \_\_\_\_\_  
Principal

Received by \_\_\_\_\_ Date \_\_\_\_\_  
Nurse

