Self – Medication for Asthma Inhalers
Authorization Form

Student Name: _____ Date: _____

Address: _____

Medication name: _____

Dosage: _____

Date administration is to begin: _____ Date administration is to stop: _____

Adverse reactions that should be reported to the physician: _____

Procedure to follow in the event medication does not produce the expected relief from the asthma attack:

_____

Other special instructions: _____

Physician's name: _____ Phone: _____

Physician's signature: _____ Date: _____

Parent/Guardian name: _____

Parent/Guardian signature: _____

Phone: Work _____ Home _____

Cell _____