Self – Medication for Asthma Inhalers
Authorization Form

Student's Name___________________________________ Date:_____________

Address:____

Medication name:____

Dosage:____

Date administration is to begin:____

Date administration is to stop:____

Adverse reactions that should be reported to a physician:___________________________

____

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

____

____

Special Instructions:____

____

Physician's Name___________________________ **Phone:**__________________

Physician's Signature____________________________ **Date:**_______________

Parent/Guardian Name____

Parent/Guardian Signature____

Date:___________ **Parent/Guardian Work Phone:**_____________________

Parent/Guardian Home Phone:_____________________

Parent/Guardian Cell Phone:______________________