Diocese of Steubenville
Office of Christian Formation and Schools

SELF-MEDICATION FOR ASTHMA INHALERS AUTHORIZATION FORM M – 5

Student's name/birthdate _____ Name of School/Homeroom Teacher _____

Address _____ Telephone number (For Emergency contact) _____

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, signatures, and emergency phone numbers:

Physician name: _____ Phone: _____

Signature: _____ Date: _____

Parent/Guardian Name: _____ Phone: (Work) _____

(Home) _____

(Other) _____

Signature: _____ Date: _____

Copies of this completed form must be provided to Principal and the School Nurse.