AUTHORIZATION FORM for USING ASTHMA INHALERS or EPINEPHRINE AUTOINJECTORS

Name of Student _____ Date _____

Name of Drug _____ Dosage _____

Date to begin administration: _____ Expiration date of request: _____

Adverse reactions that should be reported to physician: _____

Adverse reactions for unauthorized user: _____

Procedure to follow in the event the medication does not produce the expected relief/desired effect: _____

Other special instructions: _____

PHYSICIAN AND PARENT/GUARDIAN INFORMATION

Physician's Name (printed) _____ Physician's Phone Number _____

Physician's Signature _____ Date _____

Parent/Guardian Name (printed) _____ Address _____

Parent/Guardian Signature _____ Date _____

Work	**Home**	**Cell**	**Other**

2 copies of this form must be provided to the school of the child's attendance for the Principal and the School Nurse's File.