AUTHORIZATION FOR THE POSSESSION AND USE OF ASTHMA INHALERS, EPI-PENS, OR PRESCRIBED EMERGENCY MEDICATION

This form must be provided to the School Leader 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.