UNIVERSITY SCHOOL
Self-Medication for Asthma Inhalers Authorization Form

Student Name_________________________________________ Grade _______ Date ____________

Medication Name _______________________________________

Dosage_____________________________ Frequency___________________________

Date administration is to begin _____________________________________________

Date administration is to cease _____________________________________________

Adverse reactions that should be reported to the physician:
_______________________________________________________________________

Procedure to follow in the event that medication does not produce the expected relief from student’s asthma attack:
________________________________________________________________________

Other Special Instructions (including students’ peak flow reading)*
________________________________________________________________________

* A peak flow meter is available for use in the clinic.

SIGNATURE BELOW INDICATES THAT THE STUDENT HAS BEEN INSTRUCTED IN PROPER USE OF HIS INHALER AND IS AWARE THAT THE INHALER IS NOT TO BE SHARED WITH ANY OTHER PERSON. THE STUDENT IS ALSO AWARE THAT THE NURSE OR OFFICE PERSONNEL MUST BE NOTIFIED IF THE TREATMENT IS INEFFECTIVE.

Physician’s Name ___________________________ Telephone __________

Physician’s Signature_________________________________ Date ______________

Parent/Guardian Name ___________________________ Phone (work)_____________

PLEASE PRINT
Phone (home)______________
(office)__________________

Parent Signature_____________________________________ Date ________________

Student Signature____________________________________ Date ________________