CHAGRIN FALLS EXEMPTED VILLAGE SCHOOLS

REQUEST FOR SCHOOL PERSONNEL TO ADMINISTER ASTHMA MEDICATION

The following student is under my care and should receive the medication indicated below. If it is not possible to arrange for this medication to be taken at home under the supervision of a parent **or the student is unable to self-administer their asthma medication it should be administered by school personnel including the student's athletic coach**.

Student Name: _____

(PRINT FIRST NAME) **(PRINT LAST NAME)**

Current Grade: _____ **Date**: _____

ADDRESS: _____

(STREET NUMBER AND NAME, CITY, STATE AND ZIP)

Name of Medication: _____Dosage_____

Number of Times or Interval Medication is to be given:_____

Date to Begin Administration: _____Date to End Administration: _____

Adverse reactions that should be reported to Physician:

Adverse reactions for unauthorized user:

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

Other special instructions:

PHYSICIAN AND PARENT/GUARDIAN NAMES, SIGNATURES, AND EMERGENCY PHONE NUMBERS:

Physician Name: _____ Phone: _____ Fax: _____

***Physician Signature**: _____Date_____

Parent/Guardian Name: _____

(Please Print First and Last Name)

****Parent/Guardian Signature:** _____ Date:_____

Home Phone:_____ Cell Phone:_____ Work Phone_____

COPIES TO: School Nurse, Pupil Services, Parent