CHAGRIN FALLS EXEMPTED VILLAGE SCHOOLS
ASTHMA INHALERS/**SELF-MEDICATION** AUTHORIZATION FORM

Student Name: _____
(PRINT FIRST NAME) **(PRINT LAST NAME)**

Current Grade: _____ **Date**: _____

ADDRESS: _____
(STREET NUMBER AND NAME)

CITY, STATE AND ZIP: _____

Name of Medication:_____

Dosage_____

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