AUTHORIZATION FOR THE POSSESSION AND USE OF ASTHMA INHALER

WILLIAMSBURG MIDDLE HIGH SCHOOL

500 SOUTH 5TH STREET WILLIAMSBURG, OHIO 45176
PHONE 513-724-2211 FAX 513-724-6577

STUDENT NAME: _____DOB: _____
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 reaction that should be reported to physician: _____

_____

Adverse reactions for unauthorized users: _____

_____

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

_____

_____

Other special instructions: _____

_____

PHYSICIAN AND PARENT/GUARDIAN NAMES, SIGNATURES AND EMERGENCY PHONE NUMBERS ARE REQUIRED

Physician name: _____ Phone: _____

Physician signature: _____ Date: _____

Parent/Guardian name: _____ Phone: _____

Parent/Guardian signature: _____ Date: _____