**********SELF-MEDICATION FOR ASTHMA INHALERS**********

Authorization

(In accordance with ORC 3313.716/3313.14)

☐ **Please check if STUDENT is permitted by healthcare provider to CARRY an inhaler and SELF- MEDICATE at school.**

Complete the following and parent/guardian and healthcare provider must SIGN below:

Student Name _____

Medication _____

Dosage/Time(frequency) _____

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 student's asthma attack:

Other special instructions:

Prescriber and Parent/Guardian Names and Signatures REQUIRED for Self Medication of Asthma Inhalers:

Prescriber Name _____ Tel _____

Signature of Prescriber _____ Date _____

Parent/Guardian Name(s) _____ Tel _____

Signature of Parent/Guardian _____ Date _____

Copies must be provided to the principal and to the nurse.