

ANTHONY WAYNE LOCAL SCHOOLS

**AUTHORIZATION FOR THE POSSESSION AND USE OF ASTHMA
INHALER/OTHER EMERGENCY MEDICATION(S)**

Student Name: _____ Date: _____

Authorization is hereby given for the student named above to:

- Receive the prescribed medication indicated from the designated school personnel.
- Keep emergency medication in his/her possession.
- Self-administer the prescribed medication as permitted by law.

Medical Diagnosis: _____

Medication Name: _____

Dosage: _____

Date the administration is to begin: _____

Date the administration is to cease: _____

Adverse reactions that should be reported to the prescriber: _____

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

Other special instructions: _____

Prescriber and parent/guardian names, signature, and emergency phone numbers are required.

Prescriber name: _____ Phone: _____

Signature: _____ Date: _____

Parent /guardian name: _____ Emergency phone _____

Signature: _____ Date: _____