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

Student Name:	Date:
Address:	·
Authorization is hereby given for the student na	amed above to:
personnel. [] keep emergency med	ed medication indicated from the designated school ication in his/her possession.  escribed medication as permitted by law.
Medication Name:	
Dosage:	
Date the administration is to begin: Date the administration is to cease:	
Adverse reactions that should be reported to the	ne prescriber:
Adverse reactions for unauthorized user:	
Procedure to follow in the event that medicate asthma attack or other condition requiring eme	ion does not produce the expected relief from student's rgency medication:
Other special instructions:	1
Prescriber and parent/guardian names, sign	nature, and emergency phone numbers are required.
Prescriber name:	Phone:
Signature:	Date:
Parent/guardian name:	Phone: (Home)(Work)(Other)
Signature:	Date:
Copies must be provided to Principal and to building.	the School Nurse if one is assigned to the student's