MADEIRA CITY SCHOOLS

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

Student Name: _____ Date of Birth: _____

Address: _____

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

Medication Name: _____

Dosage: _____

Date the administration is to begin: _____

Date the administration is to cease: _____

Adverse reaction that should be reported to the prescriber: _____

Adverse reactions for unauthorized users: _____

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 Name: _____ Phone (home) _____
(Work) _____
(Other) _____

Signature: _____ Date: _____