Board of Education Form 9.10aF
Findlay City School District

Self-Medication For Asthma Inhalers

Authorization Form

Student Name: _____ Date: _____

Address: _____

Medication Name: _____

Dosage: _____

Date the administration is to begin: _____

Date the administration is to cease: _____

Adverse reaction that should be reported to the 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: _____

_____

Physician and parent/guardian names, signatures and emergency phone numbers:

Physician Name: _____ Phone: _____

Signature: _____

Parent/Guardian Name: _____ Phone (work): _____
(print name) Phone (cell): _____
Phone (other): _____

Parent/Guardian Signature: _____

I hereby authorize that the above-named student may carry an asthma inhaler for the sole purpose of self-medication, when necessary. Any unauthorized use of this medication may subject the child to discipline under the Findlay City District's Board Policies.

Principal: _____ Date: _____

Copies must be provided to Building Principal, School Nurse, and Director of Transportation, if applicable.

Adopted 11/15/99
Reviewed 6/13/05
Reviewed 6/18/2012