

HAMILTON LOCAL SCHOOLS

775 Rathmell Rd., Columbus, OH 43207

SELF MEDICATION AUTHORIZATION FORM
Self-Medication for Asthma Inhaler

Student Name: _____ **Date** _____

Address: _____

Medication Name: _____

Dosage: _____

Date the administration is to begin: _____

Date the administration is to end: _____

Adverse reactions that should be reported to the physician: _____

Adverse reactions for unauthorized users: _____

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

Other special instructions: _____

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

Physician Name: _____

Phone: _____

Physician Signature: _____

Date: _____

Parent/Guardian Name: _____

Phone: (home) _____

(cell) _____

(work) _____

Signature of Parent/Guardian: _____

Date: _____