MILFORD CHRISTIAN ACADEMY

SELF-MEDICATION FOR ASTHMA INHALERS/EPINEPHRINE AUTOINJECTOR AUTHORIZATION FORM

Student Name: _____ Date: _____

Address: _____

Medication Name: _____

Dosage: _____

Date the administration is to begin: _____

Date the administration is to cease: _____

Adverse reactions that should be reported to 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 name: _____ Phone: _____

Signature: _____ Date: _____

Parent/guardian name: _____

Phone: (w) _____ (h) _____ (other) _____

Parent/Guardian Signature: _____ Date: _____