Complies with state requirements (ORC 3313.716)

Saint Ignatius High School Fax 216-651-6313
Self-Medication for Asthma Inhalers Authorization Form

To be Completed by Physician/Authorized Prescriber

Student Name: ______________________________________ Birthdate__________ Grade ____

Diagnosis: __________________________ Name of Inhaler: ___________________________

Dosage:____________________ Frequency ___________________ Time(s) _______________

Is student responsible and capable of self-administering this medication? Yes No
May student carry this medication in school? Yes No **Start date ______** **End date ______**

Adverse reactions that should be reported to the physician: ________________________________
____
Procedure to follow in the event that medication does not produce the expected relief:
____

Medications/doses at home: ____
List all that apply

____ _______________
Physician/authorized prescriber signature Date

Printed Name ____ Phone ______________________

**To Be Completed by Parent/Guardian

****My son's asthma triggers are: ____**

****His early symptoms are: ____**

** I give permission for my son, ____________________________, to receive the above medication at school according to the prescriber's order and school policy It is understood that Saint Ignatius High School and all of its personnel are absolved from any liability which might be associated with the administration of such medication. I understand that the medication must be brought to school in the container in which the pharmacist dispensed it. I give permission to the School Nurse to communicate with the prescriber regarding my child's treatment plan.

I ***do not* choose to have my son, __________________________________ carry an inhaler to

school for the following reason:____.

Signature of parent: ___________________________ Date _____________________

Mother ___________________________ ___________________________
(work phone (cell phone)

Father ___________________________ ___________________________
(work phone) (cell phone)

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