FREMONT CITY SCHOOLS
500 W. State Street, Suite A, Fremont, Ohio 43420
Phone: 419-332-6454 * Fax: 419-334-5454

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

Student Name:_____ Date:_____

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 reactions that should be reported to the prescriber:_____

_____

Adverse reactions for unauthorized user:_____

_____

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/Guardian Name:_____ Phone: (Home)_____

(Work)_____

(Other)_____

Signature:_____ Date:_____

Copies must be provided to Principal and to the School Nurse if one is assigned to the student's building.