Authorization for the
Possession and Use of Asthma Inhalers
Parkway Local Schools

Student Name: _____ School: Parkway Local Schools

Grade: _____

Authorization is hereby given for the student named above to:

[] self-administer the prescribed medication as permitted by law.

Medication Name: _____

Dosage: _____

Date administration is to begin: _____, 20____
Date administration is to cease: _____, 20____

Note any adverse reactions to watch out for: _____
_____
_____

Describe the procedure to follow in the event that the medication does not produce the expected relief: _____
_____
_____
_____

Other specific instructions: _____
_____
_____
_____

Physician signature and phone number are required.

Physician Signature: _____ Phone: _____

Physician Printed Name: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

(Copies must be given to the school nurse, Patty Hipply RN,BSN, before inhalers can be used at school. Parkway Elementary Fax 419-363-2598)