LEXINGTON LOCAL SCHOOL DISTRICT

AUTHORIZATION FOR THE POSSESSION AND USE OF ASTHMA INHALERS

Student Name: _____ Date: _____

Address: _____

Authorization is hereby given for the student named above to:

( ) receive the prescribed medication indicated from the designated school personnel

( ) 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 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 and parent/guardian names, signature, and emergency phone numbers are required.

Physician 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.