ELIDA LOCAL SCHOOLS

AUTHORIZATION FOR THE POSSESSION AND USE OF **ASTHMA** INHALER**/**OTHER EMERGENCY MEDICATION(S)
(In accordance with ORC 3313.716/3313.14)

Student Name: _____ Date of Birth _____ Gr. ____ 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: _____

Prescriber Signature: _____ Date _____

Parent/Guardian name: _____ Phone: (Home) _____
(Work) _____
(Other) _____

Parent/Guardian Signature: _____ Date: _____

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

10/03
11/05
7/07
10/4/17
9/5/18