The Lillian and Betty
Ratner School

WHERE EACH CHILD THRIVES

AUTHORIZATION FORM
SELF-MEDICATION
FOR ASTHMA INHALERS

Student Name: _____ Date of Birth: _____

Address: _____

TO BE COMPLETED BY PHYSICIAN

Medication Name: _____ Dosage: _____

Frequency: _____

Start Date: _____ Stop Date: _____

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 SIGNATURES AND EMERGENCY PHONE NUMBERS

Physician's Name: _____ Phone: _____

Signature: _____ Date: _____

TO BE COMPLETED BY PARENT/GUARDIAN:
I give permission for my child _____ to self-medicate with his/her asthma inhaler at school according to school policy as instructed by the physician and agree to the following:

* to deliver medication to school in the original container,
* to have a new form completed by the physician if medication or dosage is changed or discontinued,
* to notify the school if we change physicians,
* to grant immunity to The Lillian and Betty Ratner School and its employees for good faith actions in connection with this permission,
* to have my child report to and notify school personnel when the inhaler is used.

Parent's/Guardian's Signature: _____ Date: _____

Day Phone Numbers: _____