SELF-MEDICATION FOR ASTHMA INHALERS AUTHORIZATION FORM

Student Name:_____ Date: _____

Address: _____

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's Name Phone Number

_____ _____
Physician's Signature Date

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Parent/Guardian

I, individually and as the parent/guardian of the student mentioned above, release, indemnify, and hold harmless the Archdiocese of Cincinnati, the School, the Parish, and their employees, agents, and religious from any liability, claim, damage, cost, expense, or fee that arises, directly or indirectly, out of the presence of the medication/inhaler in the School or its use by the student.

_____ _____
Parent/Guardian Name Phone Number

_____ _____
Parent/Guardian Signature Date