

St. Dominic School

SELF-MEDICATION FOR ASTHMA INHALERS Authorization 2009-2010

Student Name: _____ Date: _____

Medication Name: _____

Dosage: _____

Date the medication is to begin: _____ To end: _____

Adverse reactions that should be reported to the physician: _____

Special instructions: _____

Physician and parent/guardian names, signatures and emergency
phone numbers:

Physician Name: _____ Phone: _____

Signature: _____ Date: _____

Parent/Guardian Name: _____ Phone: _____

(work)

Signature: _____ Phone: _____

(home)

Date: _____ Phone: _____

(other)