DEARBORN HEIGHTS SCHOOL DISTRICT #7

AUTHORIZATION FOR THE POSSESSION AND USE OF ASTHMA INHALERS, EPI-PENS, OR PRESCRIBED EMERGENCY MEDICATION

This form must be provided to the principal assigned to the building of student attendance. Appropriate school staff should be notified.

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/allergic reaction: _____

_____

Other special instructions: _____

_____

Any additional information required should be attached to this form.

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

Received by _____ Date _____
Principal

Received by _____ Date _____
Nurse

2/03
5/19/03
11/04