GALION CITY SCHOOL DISTRICT

Nursing Office
Administrative Center
470 Portland Way North
Galion, Ohio 44833
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www.galionschools.org

AUTHORIZATION FOR THE POSSESSION AND USE OF ASTHMA INHALER/ OTHER EMERGENCY MEDICATION(S)

Student name:_____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 Address: _____

Signature: _____ Date:_____

Parent/Guardian name: _____ Phone: (home) _____
(work)_____ (cell) _____

Address: _____

Signature: _____ Date:_____

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