Niles Community Schools

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

THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT TO USE ABOVE MEDICATIONS OR TO RECEIVE TREATMENT IN SCHOOL. ALL SPACES MUST BE COMPLETED.

Student Name: ____ Address: ____
Last First

School Attending: ____ Current Grade: ______________________________________

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.

The student possesses an:

_____ inhaler _____ epi-pen _____ other: ____

Name of Medication: ____

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: ____

Printed Physician Name: ____ Phone: _______________________________

Physician Signature: ____ Date: ________________________________

Parent/Guardian Signature: ____ Date: ________________________________

Home Phone: ____ Cell Phone: ____

Received by Principal (Name): ____ Date: ___________________________________

08/2017

Any additional information required should be attached to this form.