



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: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Phone: (Home) \_\_\_\_\_  
(Work) \_\_\_\_\_  
(Other) \_\_\_\_\_

Signature: \_\_\_\_\_  
Date \_\_\_\_\_

Received by \_\_\_\_\_ Date \_\_\_\_\_  
Principal

Received by \_\_\_\_\_ Date \_\_\_\_\_  
Nurse