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.