

Self - Medication for Asthma Inhalers

As required by Section 3313.716 Ohio Revised Code

Student name: _____ Date: _____

Address: _____

City: _____ State: _____ ZIP: _____

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: _____

Other special instructions: _____

Physician and parent/guardian names, signatures and emergency phone numbers:

Physician name: _____ Phone: _____

Signature: _____ Date: _____

Parent/guardian name: _____

Phone: work: _____ home: _____ other: _____

Signature: _____ Date: _____

Copies must be provided to the principal and to the school nurse if one is assigned to the student's building.