



# Olney Friends School

61830 Sandy Ridge Road, Barnesville, OH 43713  
www.olneyfriends.org

## AUTHORIZATION FOR STUDENT POSSESSION AND USE OF AN ASTHMA INHALER

Student Name: \_\_\_\_\_ Birth date: \_\_\_\_\_

### PART A: TO BE COMPLETED BY THE STUDENT'S PHYSICIAN

I request that the above named student be permitted to carry and self-administer his/her asthma inhaler at school. The student has been trained and is proficient in self-administering the medication.

Name of medication \_\_\_\_\_

Prescribed dosage and time to be taken \_\_\_\_\_

If taken "When Needed" describe indications for use \_\_\_\_\_

How soon can the dose be repeated? \_\_\_\_\_

Possible adverse reactions \_\_\_\_\_

Procedure for school employees to follow if the medication does not produce the expected relief \_\_\_\_\_

Physician's signature \_\_\_\_\_ Date \_\_\_\_\_

Physician's phone number \_\_\_\_\_

### PART B: TO BE COMPLETED BY PARENT/GUARDIAN

I give permission for my child to self-administer the above mentioned medication. I will provide the medication along with clearly written directions.

I hereby release and hold harmless the school and its employees from all liability for injuries or other damages which may result from self-administration or misuse/abuse of the above mentioned medication.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

### MEDICATION CONTRACT

I understand that I am to use the above mentioned medication as prescribed by my physician. I will be responsible in using my medication and will keep it readily accessible. I have been instructed on the proper self-administration of this medication and understand the side effects of improper use. I understand that if I do not abide by these rules I may forfeit my right to carry and self-administer this medication.

Student signature \_\_\_\_\_ Date \_\_\_\_\_