**SOUTHWEST LOCAL SCHOOL DISTRICT**
**PERMISSION TO SELF-ADMINISTER ASTHMA INHALER**

Date _____

_____ _____
(Name of Student) (Address of Student)

is under my care and should be permitted to carry and self-administer an asthma inhaler on school grounds and at school activities under the conditions listed below:

Name of medication: _____

Dose contained in container: _____

Date the administration of medication is to begin: _____/_____/_____

Date the administration of medication is to end: _____/_____/_____

Procedures to be followed by school personnel if the medication does not produce the expected relief from an asthma attack:

_____
_____
_____

Any severe reactions that may occur to the child and which should be reported to the physician:

_____
_____
_____

Any severe reactions that may occur to another child for whom the inhaler is not prescribed, should such a child receive a dose of the medication:

_____
_____
_____

_____ _____
(Physician's signature) (Address)

Office phone number: _____ Emergency number: _____

_____ Phone number: _____
(Parent's/Guardian's signature)

Emergency number: _____

Copy to Principal and School Nurse