CLEARVIEW LOCAL SCHOOLS
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 of medication is to begin____

Date the administration of medication is to cease ____

Adverse reactions that should be reported to the physician _______________________________________

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Adverse reactions for unauthorized user ____

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Procedure to follow in the event that medication does not produce the expected relief from student's asthma attack ____

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Other special instructions ____

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

Physicians name ____ Phone _______________________

Signature ____ Date ________________________

Parent/guardian name ____

Phone Numbers Work __________________ Home _________________ Other __________________

Signature ____ Date ___________________

****Copies of this completed form must be provided to the principal and the school nurse in the student's assigned building.**

Compliments of the Ohio Association of School Nurses, P.O. Box 162, Worthington, OH 43085