MEDICAL AUTHORIZATION

STUDENT SELF-ADMINISTRATION
OF ASTHMA MEDICATION

_____ is currently a patient under my care being treated for asthma.

I hereby affirm that he/she has been instructed in the proper self-administration of the prescribed asthma medication(s) listed below:

Name of medication(s):_____

Dosage: _____

Frequency with which the prescribed medication(s) is/are to be administered: _____

_____

_____

The length of time for which the medication(s) is/are prescribed for: _____

_____

SPECIAL INSTRUCTIONS OR CIRCUMSTANCES, IF ANY, UNDER WHICH THE MEDICATION(S) SHOULD BE ADMINISTERED:

_____

_____

_____

_____

_____ _____

SIGNATURE of attending physician or his/her authorized agent *PRINTED name of attending physician or his/her authorized agent*

OFFICE ADDRESS:

_____ Date: _____

_____ Phone: (_____) _____

_____