BUCKEYE CAREER CENTER

SELF-MEDICATION FOR INHALERS

Please print legibly and complete all areas

Student Name: _____ **Date**: _____ **School**:_____

Address: _____

City: _____ **State**:_____ **Zip**: _____

EMERGENCY ASTHMA MEDICATIONS

	Name	Amount	When to use
1.			
2.			
3.			

Date to begin administration:_____ **Date to cease administration**:_____

Adverse reactions to report to the physician: _____

_____

_____

Adverse reactions for unauthorized user: _____

_____

_____

Procedure in the event that medication does not produce the expected relief form student's asthma attack: _____

_____

_____

Other special instructions: _____

_____

FOR INHALED MEDICATIONS

Please check the one that applies:

☐ I have instructed _____ in the proper way to use his/her medications. It is my professional opinion that _____ should be allowed to carry and use that medication by him/herself.

☐ It is my professional opinion that _____ should not carry his/her medication by him/herself.

Physician Name: _____ **Phone**: _____

Signature: _____ **Date**: _____

Parent/Guardian Name: _____

Work Phone: _____ **Home Phone**: _____ **Other Phone** _____

Signature: _____ **Date**: _____