

Self-Medication for Asthma Inhalers
As required by Section 3313.716 Ohio Revised Code

Student Name: _____ Date: _____

Address _____

City: _____ State: _____ ZIP: _____

Dosage: _____

Date the administration is to begin: _____

Date the administration is to cease: _____

Adverse reaction that should be reported to the physician: _____

Adverse reactions for unauthorized user: _____

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

Other special instructions: _____

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

Physician name: _____ Phone: _____

Signature: _____ Date: _____

Parent/guardian name: _____

Phone: Work: _____ Home: _____ Other: _____

Signature: _____ Date: _____

Copies must be provided to the principal and to the school nurse if one is assigned to the student's building.