WHITEHALL DISTRICT SCHOOLS

AUTHORIZATION FOR THE POSSESSION OF PRESCRIBED ASTHMA INHALERS, EPI-PENS, INSULIN OR GLUCAGON

Student Name: _____ Birthdate _____

Address: _____

1. Authorization is hereby given for the student named above to: (PLEASE CHECK ONE)

   ☐ Receive the prescribed medication from the designated school personnel.

   ☐ Self-administer the medication as permitted by law.

2. Medication Name: _____

   Dosage amount: _____

   Frequency to give: _____

3. Adverse reactions that should be reported to parent: _____

4. Procedure to follow if medication does not produce the expected relief: _____

   _____.

5. Other special instructions:_____

   _____.

6. Physician name: _____ Physician Contact #:_____

_____

Parent / Guardian Name **(PLEASE PRINT)**

_____ _____

Parent / Guardian Signature Date

Contact Numbers: Home: _____

Cell: _____ Work: _____

** Please submit form with the most up to date Action Plan. **