Ohio Department of Health
Authorization for Student Possession and Use of an Asthma Inhaler/Nebulizer Machine
In accordance with ORC 3313.716/3313.14

This section must be completed and signed by the student's parent or guardian.
A completed form must be provided to the school principal and/or nurse before the student may possess and/or use in the presence of designated school personnel an asthma inhaler in school to alleviate symptoms, or before exercise to prevent the onset of asthmatic symptoms.

Student Name	Address
School	Grade

As the Parent/Guardian of this student, I authorize my child to possess and use an asthma inhaler, as prescribed, at the school and any activity, event, or program sponsored by the student's school.

I will assume responsibility for safe delivery of the medication to school.

I will notify the school immediately if there is any change in the use of the medication or the prescribed treatment.

I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.

Parent/Guardian Signature	Date
Parent/Guardian Name (printed)	Parent/Guardian emergency telephone number ( )

This section must be completed and signed by the student's physician.

Name and dosage of medication/Frequency	
Date medication administration begins	Date medication administration ends (if known)

Physician to order how Asthma Inhaler/Nebulizer Machine is administered:

☐ Inhaler/Nebulizer stays in the clinic from designated personnel ☐ student self-administers inhaler/nebulizer ☐ student may carry own inhaler

The student above has demonstrated correct technique for the Asthma Inhaler/Nebulizer use and understanding of the physician order for emergency use.

Procedures for school employees if the medication does not produce the expected relief
Special instructions
Possible severe adverse reactions:
To the student for who it is prescribed (that should be reported to the physician)
To a student whom it is ***not*** prescribed who receives a dose

Physician signature	Date
Physician Name (printed)	Physician emergency telephone number ( )

Office use only:
Medication will be administered by staff listed on medication administration designation list.

☐ **Reviewed by authorized medication administrator**

☐ **DASL Entry**

☐ **Copy for Student's Teacher(s)**

☐ **Original Physician's Order to Nurse**

Reviewed by (nurse):_____

Date:_____