

Mattawan Consolidated School

SPECIALIZED AUTHORIZATION FORM FOR THE POSSESSION AND USE OF ASTHMA INHALERS, EPI-PENS OR PRESCRIBED EMERGENCY MEDICATION IP 5330 - F1c

This form must be provided to the principal assigned to the building of student attendance. Appropriate school staff should be notified.

Student's Name:		Date:
Address:		
Authorization is hereby given for the student named above to: <ul style="list-style-type: none"> <input type="checkbox"/> receive the prescribed medication indicated from the designated school personnel <input type="checkbox"/> self-administer the prescribed medication as permitted by law 		
Medication Name:		
Dosage:		
Date the administration is to begin:	Date the administration is to cease:	
Adverse reactions that should be reported to 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/allergic reaction:		
Other special instructions:		

Physician and parent/guardian names, signature and emergency phone numbers are required.

Physician Name:		
Physician Telephone:		
Physician Signature:	Date:	
Parent/Guardian Name:		
Parent/Guardian Telephone:		
Home:	Work:	Other:
Parent/Guardian Signature:	Date:	
Received by:	Date:	
Received by:	Date:	