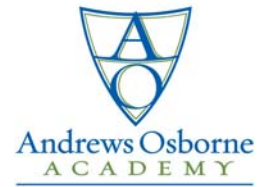


**SELF-MEDICATION FOR ASTHMA INHALERS
AUTHORIZATION
(Form H – 8) 2009 - 2010**



Deadline: August 1, 2009

Student's Name _____ Date: _____

Address: _____

City/State/Zip _____

Home Telephone: _____

Name of Medication: _____

Dosage: _____

Date to **begin**
administration _____

Date to **end**
administration _____

Adverse reactions that should be reported to physician:

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 Information

Physician name: _____ Tel: _____

Signature: _____ Date: _____

Guardian(s)
name(s): _____

Home Telephone: _____

Work Telephone: _____

Other Telephone: _____

Signature(s): _____ Date: _____

Signature(s): _____ Date: _____

ASTHMA INHALER LAW is printed on the reverse side of this sheet.