



**Authorization for Student Possession and Use of an Asthma Inhaler**

In accordance with ORC 3313.716/3313.14

**A completed form must be provided to the school principal and/or nurse before the student may possess and use an asthma inhaler in school to alleviate asthmatic symptoms, or before exercise to prevent the onset of asthmatic symptoms.**

School:	Grade:	Year:
Student's Last Name:	First Name:	<input type="checkbox"/> M <input type="checkbox"/> F Date of Birth:
<p>I have read and understand the Mayfield City School guidelines for giving medications. 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 or in which the student's school is a participant.</p>		
<p>_____/_____/_____ (_____) _____ (_____) _____</p>		
Date	Parent/Guardian Signature	Home/Cell Phone      Emergency Phone

**The following section must be completed by the LICENSED PRESCRIBER:**

Name and Dosage of Medication:	
Date Medication Administration Begins:	Date Medication Administration Ends (if known):
Procedure for School Employees if the Medication Does Not Produce the Expected Relief:	

**Possible Severe Adverse Reactions:**

To the Student for Which it is Prescribed (that should be reported to physician):
To a Student for Which it is NOT Prescribed Who Receives a Dose:

Special Instructions:
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(Licensed Prescriber's Stamp)	Licensed Prescriber's Printed Name:
	Licensed Prescriber's Signature:
	Date: ____/____/____
	Telephone Number: (____) _____

Rev 2/23

Adapted from the Ohio Association of School Nurse HEA 4223 3/11  
\*\*\*Please note a new form is required every school year

**SCHOOL FAX NUMBERS**

High School: 440.995.6805  
Middle School: 440.449.1413  
Center: 440.995.7405

Gates Mills: 440.995.7505  
Lander: 440.995.7355  
Millridge: 440.995.7255

Excel TECC: 440.995.6755  
CEVEC: 440.646.1117  
Preschool: 440.995.6805