Authorization for Administration of Inhaled Asthma Medications

School ______________________________

Student's Full Name ______________________________

Sex ☐ Male ☐ Female Date of Birth ___/___/___

For Completion by Physician

Physician's Name ______________________________

Telephone Number ( ) ______ Fax Number ( ) ______ Emergency Number ( ) ______

Name of the Medication ______________________________

Form ______________ Dose ______________

Is the child knowledgeable about his/her asthma medication? ☐ Yes ☐ No

Has the child demonstrated the proper technique in administering medication? ☐ Yes ☐ No

Medicine is administered daily ☐ Yes ☐ No If yes, what time ______________

Medicine is administered as needed. ☐ Yes ☐ No If yes, what are the indications ______________

If needed, how soon can administration of medicine be repeated? ______________

The medication can not be repeated more than ______________

Side effects: ______________________________

Comments: ______________________________

☐ I have instructed ______(insert child's name)______ in the proper way to use his/her inhaled asthma medication. It is my professional option that he/she should be allowed to carry and use this inhaled medication by him/herself.

☐ In my professional option ______(insert child's name)______ should not carry/administer the inhaler asthma medication by him/herself.

____

Physician's Signature Date

For Completion by Parent

Mother's Name ______ Mother's Phone Number ( ) ______ Mother's Work Phone ( ) ______

Father's Name ______ Father's Phone Number ( ) ______ Father's Work Phone ( ) ______

Emergency Contact Name ______ Primary Phone Number ( ) ______ Alt. Phone Number ( ) ______

Is the child authorized to carry and self-administer inhaled asthma medication? ☐ Yes ☐ No

As a parent of the above named student, I ask that assistance be provided to my child in taking the medication indicated above at school by authorized staff. If self-medicating is allowed or if no authorized staff member is available, I ask that my child be permitted to self-medicate as authorized by the child's physician and myself. Authorization is hereby granted to release this information to any appropriate school personnel and teachers who interacts with my child.

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Parent/Guardian Signature Date