AUTHORIZATION FOR USE OF INHALERS AT SCHOOL

Student Name:_____ Birth Date:_____

School:_____ Grade:_____

THIS PORTION TO BE COMPLETED BY PHYSICIAN/DENTIST/PROVIDER

Name of Medication	Dosage	Route	Time of Day

If given pm specify the length of time between doses_____

Inhalers:_____

Indicate if student must carry on his/her person

Student is capable of self-administration of medication _____Yes_____No

Possible side effects of medication_____

It is safe for unlicensed staff to provide this student this medication_____Yes_____ No

Emergency procedure in case of serous side effects_____

I request and authorize that the above-named student be administered/provided the above-identified medication in accordance with the instructions indicated above from_____ to_____ (not to exceed the current school year) as there exists a valid health reason which makes administration of the medication advisable. during school hours.

_____ _____

Date of Signature *Physician/Dentist/Provider Signature*

_____ Name: _____

Telephone Number *(Print or Type)*

Please Note: If samples of medication are to be given, they must be labeled with the name of the student, dosage, route, and time to be given

THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

I request/authorize the school to give medication to my student in accordance with the health care provider's instructions written above. I understand that unlicensed staff may be assigned to provide medication to my student, and I accept ultimate res[P]onsibility for monitoring the effects of this medication.

Permission to carry inhaler_____Yes____No Permission to self-administer medication___Yes___No

_____ _____ Phone # _____ _____

Date *Parent/Guardian/Caretaker Signature* *Home* *Work*

CONTRACT FOR STUDENTS KEEPING INHALERS WITH THEM WHILE AT SCHOOL

I plan to keep my inhaler with me at school rather than in the school health office.

I agree to use my inhaler in a responsible manner, in accordance with my physician's orders.

I will notify the school health office if I am having any difficulty with my asthma.

I will not allow any other person to use my inhaler.

Student's Signature: _____

Parent's Signature:_____

Principal's Signature:_____

Date_____