Authorization - Administration of Inhaled Asthma Medications

Student's Full Name: ____

Grade: ____________ **Date of Birth**: ______/_______/____________

For Completion by Physician

Physician's Name: ____

Phone #: (_____) ______-__________ Fax #: (_____) ______-__________ Emergency phone #: (_____) ______-_________

Name of the Medication: ____

Form: ______________________________________ Dose: ____

Is the child knowledgeable about their 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 the medicine be repeated? _______________________________________

The medication cannot be repeated more than: ____

Side Effects: ____

Additional Comments: ____

☐ I have instructed (child's name) _____________________________ in the proper way to use their inhaled asthma medication. In my professional opinion, they should be allowed to carry and use this inhaled asthma medication by themselves.

☐ In my professional opinion, (child's name) _____________________________ should NOT carry/administer the inhaled asthma medication by themselves.

Physician's Signature: ____ **Date**: __________________________

For Completion by Parent

Mother/guardian name: ____________________ Phone #: (___) ____-________ Work phone #: (___) ____-________

Father/guardian name: _____________________ Phone #: (___) ____-_________ Work phone #: (___) ____-________

Emergency Contact Name: __________________ Phone #: (___) ____-________ Work phone #: (___) ____-________

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 interact with my child.

Parent/Guardian Signature: ____________________________________ **Date**: __________________________