AUTHORIZATION FOR ADMINISTRATION OF INHALED ASTHMA MEDICATIONS
(Use a separate authorization form for each medication)

Student's Name_____
Last First Middle

Sex: (please circle) Female Male Birth date_____

COMPLETION BY PHYSICIAN

Physician's Name_____
Telephone Number _____Fax Number_____
Emergency Contact Number_____
Diagnosis_____ Name of Medicine_____
Form_____Dose_____

Is the child knowledgeable about his or her asthma medication? YES ☐ NO
Has the child demonstrated the proper technique in administering medication? Yes ☐ NO ☐
Medicine is administered daily. Yes ☐ NO ☐ Time_____

Medicine is administered when needed. Indications_____
_____

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

The medication cannot be repeated more than_____

Side effects_____
_____

Comments_____
( ) I have instructed _____in the proper way to use his/her inhaled asthma medications. It is my professional opinion that he/she should be allowed to carry and use this inhaled medication by him/herself.
( ) It is my professional opinion that _____should not carry and use his/her inhaler asthma medication by him/herself.

Physician Signature_____Date_____

*****Please see reverse side for more information.**

Continued…

COMPLETION BY PARENT

Parents Name_____
Mother Father
Work _____
Mother Father
Cell_____
Mother Father
Home_____
Mother Father
Emergency Number_____

Is the child authorized to carry and self-administer inhaled asthma medication? ☐ YES ☐ NO
As the parent of the above named student, I ask that assistance be provided to my child in taking the medicine(s) 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 myself and my physician. Authorization is hereby granted to release this information to appropriate school personnel and classroom teachers.

Parent/Guardian Signature _____Date_____