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

School:_____ Student's Name _____

Sex: (please circle) Female Male Birthdate: _____/_____/_____

FOR 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. Time:_____ _____Yes _____No

Medicine is administered when needed. 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 _____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_____

FOR COMPLETION BY PARENT

Mother's Name:_____ Father's Name: _____
Mother's Work Number_____ Father's Work Number_____
Home Telephone Number_____ 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 my physician and myself. Authorization is hereby granted to release this information to appropriate school personnel and classroom teachers. I hereby agree to hold the Chilton School District and all employees harmless in any and all claims arising from the administration of this medication at school.

Parent/Guardian Signature:_____ Date:_____