Howard - Suamico School District

AUTHORIZATION FOR ADMINISTRATION OF INHALED ASTHMA MEDICATIONS

(Use a separate authorization form for each medication)

Student's Name: ___________________________________ Birthdate: ______________________

School/Grade: _____________________________________

FOR COMPLETION BY PHYSICIAN

Physician's Name: ____

Telephone Number: ________________________________ Fax Number: _________________

Name of Medication:________________________________ Inhaler ___ Nebulizer ___ Spacer ____

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

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

Is medication administered daily? _____ Time: ____________________ ☐ Yes ☐ No

OR

Is medication administered when needed. Indications for use: _____________________________________

____

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

The medication can not be repeated more than ____

Side effects/comments: ____

____

Is this a scheduled medication: _____ OR As needed medication? _____

( )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

Parent Telephone #1: __________________________ Parent Telephone #2: ___________________

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 – print: ___________________________________ **Date:** _________________

Parent/Guardian Signature: _________________________________