

# Authorization for Administration of Inhaled Asthma Medications

School \_\_\_\_\_

Student's Full Name \_\_\_\_\_

Sex  Male  Female Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

## For Completion by Physician

Physician's Name \_\_\_\_\_

Telephone Number ( ) \_\_\_\_\_ Fax Number ( ) \_\_\_\_\_ Emergency Number ( ) \_\_\_\_\_

Name of the Medication \_\_\_\_\_

Form \_\_\_\_\_ Dose \_\_\_\_\_

Is the child knowledgeable about his/her 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 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 medication.  
(insert child's name)  
It is my professional option that he/she should be allowed to carry and use this inhaled medication by him/herself.

In my professional option \_\_\_\_\_ should not carry/administer the inhaler asthma medication by him/herself.  
(insert child's name)

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

## For Completion by Parent

Mother's Name \_\_\_\_\_ Mother's Phone Number ( ) \_\_\_\_\_ Mother's Work Phone ( ) \_\_\_\_\_

Father's Name \_\_\_\_\_ Father's Phone Number ( ) \_\_\_\_\_ Father's Work Phone ( ) \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Primary Phone Number ( ) \_\_\_\_\_ Alt. Phone Number ( ) \_\_\_\_\_

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 interacts with my child.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_