



# Baldwin-Whitehall School District

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Baldwin High School  
412-885-7500, Ext. 4  
Fax: 412-885-6652

J. E. Harrison Education Center  
412-885-7530, Ext. 4  
Fax: 885-6766

McAnnulty Elementary School  
412-714-2020, Ext. 3  
Fax: 412-714-2024

Whitehall Elementary School  
412-885-7525, Ext. 3  
Fax: 412-885-7559

## AUTHORIZATION FOR ADMINISTRATION OF INHALER AT SCHOOL

(Permission for use of other medication is on separate form.)

### PART I – TO BE COMPLETED BY PARENT/GUARDIAN

I DO  DO NOT  request that Baldwin-Whitehall School District permit the student identified below to carry an inhaler on his/her person in school and to be allowed to use it as soon as an asthmatic attack begins. I agree to relieve the Baldwin-Whitehall School District, its officers, directors and employees of any responsibility for the benefits or consequences of the prescribed medication and acknowledge that the Baldwin-Whitehall School District bears no responsibility for ensuring the medication is taken.

Before allowing the student to carry the inhaler, the school nurse will review proper use with the student. The nurse must confirm that the student demonstrates proper knowledge of administration and has the skills to safely possess and use an inhaler.

Student Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

School: \_\_\_\_\_ School Year: \_\_\_\_\_ Grade: \_\_\_\_\_

**I assure that the first dose has been given at home and that my child did not have any adverse reactions to it.**

Print or Type Name of Parent/Guardian	Parent/Guardian's Signature
Relationship to Student	Phone Number
	Date

### PART II – TO BE COMPLETED BY PHYSICIAN/LICENSED PRESCRIBER

I agree to relieve the Baldwin-Whitehall School District, its officers, directors and employees of any responsibility for the benefits or consequences of the prescribed medication and acknowledge that the Baldwin-Whitehall School District bears no responsibility for ensuring that the medication is taken.

Diagnosis	Medication	Strength	Dose	Time	Route	Possible Side Effects

Symptoms of conditions for which medication is ordered: \_\_\_\_\_

Other medication(s) the child is taking: \_\_\_\_\_

Other considerations/directions: \_\_\_\_\_

Start Date: \_\_\_\_\_ Stop Date: \_\_\_\_\_

(All authorizations expire at the end of the school year.)

I DO  DO NOT  believe that this student has received adequate education on how and when to use the inhaler and has the skills to carry it on his/her person in school.

Print or Type Name of Physician/Licensed Prescriber	Physician's/Licensed Prescriber's Signature
Address	Phone Number
	Date

### PART III – TO BE COMPLETED BY SCHOOL NURSE

Check as appropriate:

- PART I and PART II completed with all information.
- Medication is properly labeled.
- I have reviewed the proper use of the inhaler with the student.
- Student is knowledgeable about the medication and how to administer it.
- Student has the skills to safely possess and use an inhaler.
- Student may self-administer the inhaler.

School Nurse's Signature	Date
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