Hillsboro City Schools

Elementary- (937) 393-3132 Fax- (937) 393-2418
MS/HS- (937) 393-4421 Fax- (937) 393-5843

Self-Possession and Use of an Asthma Inhaler

Dear Parents/Guardians,

Please consult the prescriber to determine if this medication is necessary to have at school and if it is appropriate, safe and feasible for your child to self-carry and self-administer an asthma inhaler.

Before a student may possess and self-administer an asthma inhaler in school, the State of Ohio law (Section 3313.716/3313.14 O.R.C.) requires the following:

1. The parent must complete and sign the parent portion of the Authorization form.
2. The licensed prescriber must complete and sign the provider portion of the form.
3. Both sections must be completed and returned BEFORE the student can carry the inhaler at school.
4. The medication must be brought to school in the original container labeled with your child's name, the provider's name, the name of the medication, the dose and time it is to be taken.
5. A new form must be completed EVERY school year.

**It is recommended that a backup inhaler be kept in the school clinic.

These policies are for the health and safety of your child. If you have any questions, please contact the school nurse.

School Nurse
Katie Greer, RN, BSN

Ohio Department of Health
Authorization for Student Possession and Use of an Asthma Inhaler
In accordance with ORC 3313.716/3313.14

A completed form must be provided to the school principal and/or nurse before the student may possess and use an asthma inhaler in school to alleviate symptoms, or before exercise to prevent the onset of asthmatic symptoms.

Student's name
Student address

This section must be completed and signed by the student's parent or guardian.

As the Parent/Guardian of this student, I authorize my child to possess and use an asthma inhaler, as prescribed, at the school and any activity, event, or program sponsored by on in which the student's school is a participant.

Parent/Guardian Signature	Date
Parent/Guardian Name	Parent/Guardian emergency telephone number ( )

This section must be completed and signed by the student's physician.

Name and dosage of medication	
Date medication administration begins	Date medication administration ends (if known)
Procedures for school employees if the medication does not produce the expected relief	

Possible severe adverse reactions:

To the student for whom it is prescribed (that should be reported to the physician)
To a student whom it is ***not*** prescribed who receives a dose
Special Instructions

Physician signature	Date
Physician Name	Physician emergency telephone number ( )

Adapted from the Ohio Association of School Nurses