LAKE MARY
PREPARATORY SCHOOL

AUTHORIZATION FOR ASTHMA MEDICATION ADMINISTRATION AT SCHOOL

School Year: 20___ to 20___

Date: _____ Student: _____D.O.B._____ Grade: _____

Asthma Triggers: _____

To Be Completed by Physician:
Current Asthma Condition: [ ] Intermittent [ ] Moderate Persistent
[ ] Mild Persistent [ ] Severe Persistent [ ] Exercise Induced

The above student has been diagnosed with asthma and, on occasion, will require the following asthma medication to be administered at school:

Medication to be administered via inhaler: Drug: _____
Dose: _____
Frequency: _____

Medication to be administered via nebulizer: Drug: _____
Dose: _____
Frequency: _____

Other Medication: Drug: _____
Dose: _____
Frequency: _____

The student has been instructed and demonstrates proper technique to administer his/her asthma medication. He/she may carry and self-administer his/her inhaler during the school day.

Yes _____ No _____ Location of Inhaler at School: _____

Comments: _____

I understand that Lake Mary Preparatory School does not have access to peak flow meters at this time.

Signed: _____Print: _____Date:_____
PHYSICIAN signature required

Signed: _____Print:_____Date:_____
PARENT/GUARDIAN signature required