

METERED DOSE INHALERS

(CONSENT FORM)

I authorize the Gordon School to administer my child's inhaler according to the physician's instructions below. If my physician has written an Asthma Action Plan for my child, I will provide a copy for the health office at school. I understand that the inhaler must have the pharmacy's prescription label affixed to the outside.

Parent/Guardian Signature

Date

PHYSICIAN'S ORDER

I give permission for the following medication to be administered as directed to the student named below for the 2024-2025 school year.

Student Name: _____

D.O.B: _____

Name of Medication: _____

Dosage of Medication: _____

Route of administration: _____

Time to be given: _____

Reason for Medication: _____

Possible Side Effects: _____

PERMISSION TO SELF-CARRY:

_____ Yes, I have instructed this student in the proper way to use his/her medication. It is my opinion that he or she should be allowed to carry and self-administer this medication at school.

_____ No, it is my opinion that this student should not carry and self-administer this medication at school.

Physician Signature

Date