CELINA INDEPENDENT SCHOOL DISTRICT
HEALTH SERVICES

Request for self-administration of prescription Metered-Dose Inhaler Form

Supplemental form to general Medication Request form

Date of Request: _____ Student's Name: _____

Birth date: ____/____/_____ Medication:_____

Dosage: _____ Indication for use: _____

Special Instructions/known side effects of medication for your child: _____

TO BE COMPLETED BY THE PHYSICIAN

My signature below indicates that:

1. The student stated above has asthma.
2. I have instructed the student indicated above in the procedure to use his/her MDI, and it is my professional opinion that this student can carry and self-administer the medication indicated above while on school property or at school-related events.
3. The student indicated above has my permission to self-administer the medication as directed above in a properly labeled container at the times and dosages shown above.

I understand that CISD reserves the right to require this medication be kept in the clinic if, in the school nurse's judgment, the student can not safely carry the medication and properly self-administer it.

I understand the parent's signature in the box below permits the appropriate school staff to contact me to obtain medical information/records. I also understand that my written request is valid for one school year and must be renewed at the beginning of each school year.

Physician Name: _____Phone: _____

Physician Signature: _____ Date:_____

TO BE COMPLETED BY THE PARENT/GUARDIAN

My signature below indicates that:

1. I permit my child to carry and self-administer the medication specified above on school property or at a school-related event or activity according to the physician's request and the CISD medication guidelines.
2. I permit appropriate school staff to contact the physician above to obtain medical information/records related to this medication as necessary for care in the school setting or school-related events or activities.

I understand that CISD reserves the right to require that this medication be kept in the clinic if, in the school nurse's judgment, my child cannot or will not safely carry the medication and properly self-administer the medication.

I also understand that this written request is valid for one school year and must be renewed at the beginning of each school year.

Parent/Guardian Name: _____ Phone: _____

Parent/Guardian Signature: _____ Date: _____