Baldwin-Whitehall School District

Administration Office: 4900 Curry Road • Pittsburgh, Pennsylvania 15236-1817
Telephone: 412-884-6300 • FAX: 412-885-7802 • Website: www.bwschools.net

Baldwin High School	J. E. Harrison Middle School	R. A. Lutz Elementary School	Whitehall Elementary School	McAnnulty Elementary School
412-885-7500, Ext. 4	412-885-7530, Ext. 4	412-885-7535, Ext. 4	412-885-7525, Ext. 3	412-714-2020, Ext. 3
Fax: 885-6652	Fax: 885-6766	Fax: 412-885-6641	Fax: 412-885-7559	Fax: 412-714-2024

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