NEBULIZER ADMINISTRATION PERMISSION FORM

HEALTH SERVICES
SCHOOL DISTRICT U-46

PARENT PERMISSION:
Please PRINT information:

Student Name: ______________________________________Date of Birth: ______________
Last Name, First Name — Month Day Year

Address: ____
House Number / Street — Apt # if necessary — City — ZIP

School: ___________________________________Grade: _______Teacher: ____________
Name of School — Teacher's Name

☐ I give my permission for the above named student to have nebulizer treatments during the school day.

☐ I give permission for the nurse to communicate as warranted with the physician and/or respiratory therapist regarding my student's health concerns.

Printed Name: _______________________Home Phone: _________Work Phone: ________
Parent/Guardian printed name — area code + number — area code + number

Signature: _____________________________________Date of signature:______________
Signature of Parent/Guardian — Month Day Year

PHYSICIAN INSTRUCTION:

☐ I request that the above named student have nebulizer treatments during the school day.

PHYSICIAN'S ORDERS: (to be completed by student's physician)

1. **Medication**: ____
   Dose: ______________________________ Frequency: _______________________
   Diagnosis: ____
   Side effects: ____
   Medical protocol may require an adjustment in dosage of this medication. Verbal orders for increase or decrease in increments of ______________________ are inherent in this order only.

2. **Medication**: ____
   Dose: ______________________________ Frequency: _______________________
   Diagnosis: ____
   Side effects: ____
   Medical protocol may require an adjustment in dosage of this medication. Verbal orders for increase or decrease in increments of ______________________ are inherent in this order only.

Comments: ____

Physician's Printed Name: _________________________Office Phone: _______________
Physician's printed name Medical Group/Clinic — area code + number

Signature: ____________________________________Date of signature:_______________
Signature of Physician — Month Day Year