TARKINGTON ISD HEALTH SERVICES

AUTHORIZATION FOR STUDENT TO CARRY ASTHMA INHALER

School: Date:

Student's name: Grade/Teacher:

Health care provider: *(Physician, Physician Assistant, Nurse Practitioner)*

Name: _____

Address: _____

Telephone: _____ Fax: _____

Medication: Name/Route/Dosage: _____

Frequency/Time of administration/assistance: _____

Diagnosis: _____

Other medical conditions requiring medication: _____

Any special side effects, contraindications, adverse reactions to be observed:_____

_____

Any severe reaction that may occur if a pupil other than the above-named used an asthma inhaler:

_____

HEALTH CARE PROVIDER'S STATEMENT

I request that the above-named student be allowed to carry _____ at school. I have verified the student's knowledge and skill to safely possess and use the medication, as required by law.

_____ _____

Provider's Signature Date

PARENT'S STATEMENT

I request that my child carry his/her medication at school. I will provide the school with an extra inhaler to keep in the health office.

_____ _____

Parent's Signature Date

_____ _____

Student's Signature Date

Emergency parent contact phone number :

School Nurse's Signature:_____ Date :_____