

**INHALER MEDICATION ADMINISTRATION AUTHORIZATION**

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ School: \_\_\_\_\_

**..... This section to be completed by HEALTH CARE PROVIDER .....**

<b>Diagnosis:</b> <input type="checkbox"/> ASTHMA <input type="checkbox"/> _____	
<b>Medication:</b> _____	
<b>Dose:</b> _____	
<b>Route:</b> INHALATION	
<b>Indications for administration:</b> <input type="checkbox"/> PRN for cough, wheezing, chest tightness, or shortness of breath <input type="checkbox"/> PRN for exercise, per student and/or parent request <input type="checkbox"/> SCHEDULED _____ minutes prior to _____ Other: _____	
<b>Time between doses:</b> _____	
<b>Possible side effects:</b> <input type="checkbox"/> Jitteriness, increased heart rate <input type="checkbox"/> Other _____	
<b>Self-carry/Self-administration Authorization</b> Do you authorize this student to self-carry this medication <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> This student is trained and capable of self-administering this medication <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>	
<b>Duration of Order:</b> <input type="checkbox"/> _____ school year, including summer school <input type="checkbox"/> Other Dates: _____	

I request and authorize that the above-named student be administered the above identified medication in accordance with the instructions indicated. There exists a valid health reason which makes administration of the medication advisable during school hours or during such time that the student is under the supervision of school officials. Medication may be administered by non-licensed school personnel.

\_\_\_\_\_  
 Health Care Provider Signature                      Printed Name                      Date                      Phone Number                      Fax Number

**..... This section is to be completed by PARENT/GUARDIAN .....**

- I authorize the school to administer the above-named medication to my student as prescribed.
- I understand that over-the-counter medication must be in its original container with a valid expiration date, and prescription medication must have a pharmacy label matching the written order above. It is my responsibility to replace medication when it is used or expired.
- If my student has permission to self-carry and/or self-administer this medication, my student and I understand the responsibilities, and recognize the school will not track compliance, expiration dates, or remaining amounts.
- I agree to hold harmless and indemnify the Lake Washington School District and its officers, employees, and agents against all claims, demands, damages, costs, judgments, or liabilities arising out of the self-administration and/or carrying of medication by my student.

\_\_\_\_\_  
 Signature of Parent/Guardian                      Printed Name                      Date