Inhaler Self-Administration

Student: _____

School: _____

Grade: _____

To Be Completed by a Physician/Practitioner:

My patient_____has been instructed in the proper use of his/her inhaler. The inhaler I have prescribed is_____. My patient is authorized to use the inhaler_____times per day or as follows:_____. The prescription for the inhaler expires:_____. This student's well being is in jeopardy unless the inhaler is carried on his/her person; therefore, we request that he/she be permitted to carry the inhaler. He/she understands the purpose, appropriate method, and frequency of the use of this medication.

Physician/Practitioner: _____
Please Print or Stamp

Address: _____

Phone #_____

Signature: _____ Date: _____

To Be Completed by Parent/Guardian:

I permit my child to carry the above listed inhaler as ordered by his/her physician/practitioner. I understand that my child, not the school, is responsible for the storage, possession, and use of the inhaler. I understand that sharing medication with other students will result in disciplinary action.

Parent/Guardian Signature: _____ Date: _____

To Be Completed by the Student:

I understand the purpose, appropriate method, and frequency of use of this inhaler. I understand that I, not the school, is responsible for the storage, possession, and use of the inhaler. I understand that sharing medication with other students is potentially dangerous and will result in disciplinary action.

Student Signature: _____ Date: _____

This form must be completed in addition to the routine medication authorization form.