Our Savior's Lutheran School

Authorization for Administration of Inhaled Asthma Medications

This form is to be completed annually be the child's physician or if changes are made during the school year.

Please return to school office upon completion.

Child's Name_________________________________ Gender ____ Birthdate___________ Age/Grade _____

Parent's Name____

Family Physician/Clinic ______________________________________ Date of last visit/physical exam _________

Telephone (_____) ______-_________ Fax (_____) ______-_________

MEDICATION INFORMATION

Medication name ____ Dose _____________________________

Is medication administered daily? ☐ Yes ☐ No If yes, at what time(s)? _______________________

Is medication administered as needed? ☐ Yes ☐ No

If yes, at what are the indications to administer? ____

____

If needed, how soon can it be re-administered? ____

Medication should not be repeated more than____

Possible side effects include____

____

Comments____

____

AUTHORIAZATION TO ADMINISTER

_____________________________ has been instructed in the proper way to use his/her inhaled asthma medication. It is my professional opinion that he/she should be allowed to carry and use this inhaled medication as prescribed if needed prior to exercise or to alleviate asthma symptoms.

___________________________________ ___________________________________

Physician's Signature School Year/Effective Dates

☐ I give my permission for my child to carry and self-administer inhaled asthma medication if needed before exercise or to alleviate asthma symptoms as directed by his/her physician.

☐ I request that my child be assisted by authorized school personnel in taking the medication described above while at school.

Authorization is also hereby granted to release this information to any appropriate school personnel who interact with my child.

___________________________________ ___________________________________

Parent/Guardian's Signature Date

Daytime Telephone (_____) ______-_________ Cell (_____) ______-_________

Emergency Contact __________________________ Relationship__________________________

Daytime Telephone (_____) ______-_________ Cell (_____) ______-_________