Authorization for Administration of INHALED Medications
Stanley-Boyd Area Schools

______________________________________ ___________
Name of Student Date of Birth

___________________________ _____
Homeroom Teacher Grade

For Completion by Physician:

Print Physician's Name:____________________________________

Telephone number:___________________ Fax number:_____________

Diagnosis:____

Name of Medication:_________________________________

Form of Medication:__________________ Dose:__________________

Is the child knowledgeable about his/her asthma medication? _____yes _____no

Has the child demonstrated the proper technique in administering the medication? _____yes _____no

Is the medication administered daily? _____yes _____no Time:___________

Medication is administered when needed. Indications:

____

If needed, how soon can administration of medication be repeated? ____________________

The medication cannot be repeated more than ________________________________

Side effects: ____

Comments: ____

( ) I have instructed ____________________ in the proper way to use his/her inhaled asthma medications. It is my professional opinion that he/she should be allowed to carry and use this inhaled medication by him/herself.

( ) It is my professional opinion that ____________________ should not carry and use his /her inhaled asthma medication by him/herself.

____ ________
Signature of physician Date

For Completion by Parent:

_________________________ __________ __________ __________
Print Parents name Home phone Work phone Emergency phone

Is the child authorized to carry and self administer inhaled asthma medication? _____yes _____no

As the parent of the above named student, I ask that assistance be provided to my child in taking the medication(s) indicated above at school by authorized personnel. If self-medicating is allowed or if no authorized staff member is available, I ask that my child be permitted to self-medicate as authorized by myself and my child's physician. Authorization is hereby granted to release this information to appropriate school personnel and classroom teachers.

_______________________________ __________
Parent/Guardian Signature Date