Self –Administered Inhalers

If you would like your child to carry and use his or her inhaler independently at school, please complete this form. *PLEASE NOTE: This form requires a signature from your physician or health care provider.* Please notify the school staff on the location of the inhaler. We do recommend that a second (back-up) inhaler be kept in the health office.

This portion to be completed by Physician for Prescription Medications only.
PHYSICIANS ORDER FOR MEDICATION

CHILD'S NAME____

DIAGNOSIS____

MEDICATION_____________________________DOSE ____________________

FREQUENCY____________________________ TIME OF DAY AT SCHOOL__________

START DATE____________STOP DATE__________OR UNTIL THE LAST DAY OF SCHOOL______

POSSIBLE SIDE EFFECTS_______________________________________

If as needed (PRN), state conditions under which medication should be given (i.e. before exercise)

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Your signature on this document attests to your willingness and intent to direct, supervise, decide, inspect, and oversee the administration of the medication by non-medically trained designees, and that you will accept direct communications from them regarding the administration of the medication. We urge that all instructions be stated in language of the lay person.

- ❑ I have instructed this student in the proper way to use his/her inhaler. It is my professional opinion that he/she should be allowed to carry and use his/her inhaler.

DATE_________________ PHYSICIAN'S NAME ______________________
(Please Print)

PHONE NUMBER______________PHYSICIAN'S SIGNATURE__________________

Parent Signature:____________________________________ Date: __________

THIS ORDER MAY BE FAXED TO THE STUDENT'S SCHOOL: