Asthma Inhaler Administration Authorization Form

Student's Name:____________________ D.O.B: __________School/Grade: ___________

Diagnosis: ____

In order for the student to receive the asthma relieving medication for asthma:

- Asthma inhaler administration authorization form will be completed and signed by parent and medical provider. Form will be given to the school district administrator or school nurse.
- Asthma inhaler medication will have the student's name, name of medication, directions for use and date.
- Authorization of asthma relieving medication will be updated annually.

The student has the skill, knowledge and my authorization to use an asthma relieving medication in the following manner:

____ Self-administer asthma relieving medication. The student will seek the care of the school personnel if medication is unsuccessful controlling his/her asthma.

____ Self-administer asthma relieving medication with access to another inhaler in the health office as needed. Parents will supply the health office secondary inhaler.

____ Student needs assistance with administration of their asthma relieving medication with the medication available as needed in the health office.

Medication Name and Strength:____

Dose:____

Route:____

Time to be administered at school:____

Date order effective from:____________________ To:___________________________

Diagnosis/Reason for Medication:____

Rib Lake School personnel may contact the medical provider of the medication for clarification regarding indication for use, medication, dosage, side effects, successful and treatment failures.

Physician's name:	Clinic/Phone:
Physician's signature:	Date:
Parent/Guardian signature	Date:

School Administrator Authorization: ______________________________ Date: _____________