SHEBOYGAN CHRISTIAN SCHOOL

Asthma Inhaler Administration Authorization Form

Student's Name:_____ D.O.B: _____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 school district administrator or school nurse.

· Asthma inhaler medication will have 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. Student will seek the care of the school personnel if medication is unsuccessfully controlling his/her asthma.

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

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

Drug name	Dosage	Route	Frequency	Start date	Stop date	Side Effects
1.						
2.						

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

Print Medical Provider Name: _____ Phone: _____
Medical Provider Signature: _____ Date: _____
Parent Signature: _____ Date: _____