

Inhaler Permission Form

All sections must be complete. Completed form must be submitted to the Executive Director or his/her designee and the School Nurse, if the school has one assigned.

To be completed by the Physician

Student Name: _____

Student Address: _____

The above-named student has the approval to possess and use the following inhaler medication to alleviate asthmatic symptoms. Use must be according to the following specifications:

Name and dose of medication: _____

Date the administration of the medication is to begin: _____

Date, if know, administration of medication is to cease: _____

The following procedure is to be employed in the event that the medication does not produce the expected relief from an asthma attack:

Please list any severe adverse reactions that may occur to the student using the inhaler that should be reported to the physician:

Please list any severe adverse reactions that may occur to another student, for whom the inhaler is not prescribed, should such student receive a dose of the medication:

Any other special instructions:

Physician Signature: _____

Physician Name (Printed): _____

Physician Address: _____

Emergency Telephone Number: _____

To be completed by a Parent or Legal Guardian

Name and emergency telephone number of a parent or guardian, or other person having care or charge of this student in an emergency:

I, as the parent or legal guardian of the above-named student, do hereby give my approval for this student's possession and use of the inhaler medication described above.

Parent/Guardian Signature _____

Parent/Guardian Name (Printed) _____