

## Authorization for Administration of Inhaled Asthma Medication

(Use a separate authorization form for each medication)

School: \_\_\_\_\_

Student's Name: (First/MI/Last) \_\_\_\_\_

Sex: (please circle) Female Male

Birthdate: \_\_\_/\_\_\_/\_\_\_

### FOR COMPLETION BY PHYSICIAN, NURSE PRACTITIONER, OR PHYSICIAN'S ASSISTANT:

Physician's Name: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Emergency Contact Number: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Name of Medicine: \_\_\_\_\_

Form: \_\_\_\_\_ Dose: \_\_\_\_\_

Is the child knowledgeable about his/her asthma medication?  Yes  No

Has the child demonstrated the proper technique in administering medication?  Yes  No

Medicine is administered daily. Time: \_\_\_\_\_  Yes  No

Medicine is administered when needed. Indications: \_\_\_\_\_

If needed, how soon can administration of medicine 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 be allowed to carry and use this inhaled medication by him/herself.

Physician Signature/Date: \_\_\_\_\_

### FOR COMPLETION BY PATIENT

Mother's Name: \_\_\_\_\_

Father's Name: \_\_\_\_\_

Mother's Work Telephone: \_\_\_\_\_ Father's Work Telephone: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Emergency Number: \_\_\_\_\_

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 medicine(s) indicated above at school by authorized staff. 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 physician. Authorization is hereby granted to release this information to appropriate school personnel and classroom teachers.

Parent/Guardian Signature and Date: \_\_\_\_\_