
BIG WALNUT

LOCAL SCHOOL DISTRICT

PHYSICIAN AUTHORIZATION FOR INHALED ASTHMA MEDICATIONS FORM

Student's Name: _____ Date: _____

Student's Address: _____

Name of Medication: _____ Dosage _____

Date medication is to begin: _____ Date medication is to cease: _____

Adverse reactions to be reported to Physician: _____

Procedures to be followed if the medication does not produce the expected relief from the student's asthma attack: _____

Other special instructions: _____

Adverse reactions to another child, for whom the inhaler is not prescribed, should such a child receive a dose of the medication: _____

Emergency Contacts:

Physician Name: _____ Phone #: _____

Parent/Guardian Name: _____

Parent/Guardian Phone: _____

Home

Work

Other

I have instructed _____ in the proper way to use his/her medications. It is my professional opinion that _____ should be allowed to carry and use that medication by him/herself.

It is my professional opinion that _____ should not carry his/her inhaled medication by him/herself. The medication as indicated above shall be administered by authorized school personnel.

Physician Signature

Date

Parent Signature

Date

(OVER)

Asthma Inhaler Contract

For permission to carry inhalers:

1. The Student has demonstrated to the nurse/assigned school personnel correct use of the inhaler.
2. Student agrees to never share the inhaler with another person.
3. Student agrees that he or she will notify an adult staff member when using his or her inhaler.

Student Signature: _____ Date: _____

I give permission for my child _____ to carry the inhaler described below. I understand that he/she must follow the rules listed above. I will notify the school of changes in medication or my child's condition.

Name of Medication	Dose	Frequency of Use
_____	_____	_____
_____	_____	_____

Parent/Guardian Signature: _____ Date: _____