Self –Administered Inhalers

If you would like your child to carry and use his or her inhaler independently at school, please complete this form. *PLEASE NOTE: This form requires a signature from your physician or health care provider*. Please notify the school staff on the location of the inhaler. We do recommend that a second (back-up) inhaler be kept in the health office.

This portion to be completed by Physician for <u>Prescription Medications</u> only.
PHYSICIANS ORDER FOR MEDICATION

CHILD'S NAME_____

DIAGNOSIS_____

MEDICATION_____DOSE _____

FREQUENCY_____ TIME OF DAY AT SCHOOL_____

START DATE_____STOP DATE_____OR UNTIL THE LAST DAY OF SCHOOL_____

POSSIBLE SIDE EFFECTS_____

If as needed (PRN), state conditions under which medication should be given (i.e. before exercise)
_____
_____
_____

Your signature on this document attests to your willingness and intent to direct, supervise, decide, inspect, and oversee the administration of the medication by non-medically trained designees, and that you will accept direct communications from them regarding the administration of the medication. We urge that all instructions be stated in language of the lay person.

- ☐ I have instructed this student in the proper way to use his/her inhaler. It is my professional opinion that he/she should be allowed to carry and use his/her inhaler.

DATE_____ PHYSICIAN'S NAME _____
(Please Print)

PHONE NUMBER_____PHYSICIAN'S SIGNATURE_____

Parent Signature:_____ Date: _____

<u>THIS ORDER MAY BE FAXED TO THE STUDENT'S SCHOOL:</u>