Asthma Inhaler Administration Authorization Form

Student's Name:			D.O.B:		_School/Grade:		
Diagnosis:							
and medical prAsthma inhale use and date.	r administra ovider. For r medication	ation authorm will be not will have	orization form v given to school	vill be co district a e, name	ompleted administ of medic	and signed by parent rator or school nurse. cation, directions for	
The student has the sk in the following mann		dge and my	y authorization	to use ar	ı asthma	relieving medication	
school p Self-adr health o Student	personnel if minister asth ffice as nee needs assis	medicationma relievaded. Parentance with	n is unsuccessfiing medication its will supply h	ully cont with acc nealth of of their	rolling heess to ar fice seco asthma	nother inhaler in the	
Drug name:	Dosage:	Route:	Frequency:	Start date:	Stop date:	Side Effects:	
1.							
2.							
School personnel may indication for use, med						2 2	
Physician's name:				Clinic/Phone:			
Physician's signature:				Date:			
Parent/Guardian signature				Date:			
School Administrator Authorization:					Date:		