PICKAWAY-ROSS
CAREER & TECHNOLOGY CENTER
ASTHMA INHALER AUTHORIZATION FORM

Student's Name_____ Date_____

Address_____

Program_____

Physician to indicate choice

_____**Student to possess and use inhaler**
_____**Inhaler administered by school personnel and locked in school office**

Medication Name_____
Dosage_____Route_____Time_____

Date the administration is to begin_____
Date the administration is to cease_____

Adverse reactions that should be reported to the physician_____

_____

Procedure to follow in the event that medication does not produce the expected relief from student's asthma attack_____

_____

Other special instructions_____

_____

Physician and parent/guardian names, signatures and emergency phone numbers:

Physician name:_____Phone_____
Physician's Address:_____

Physician's Signature_____Date:_____

Mother's Name_____ Phone: Work_____ Home_____
Father's Name_____ Phone: Work_____ Home_____
Other_____ Phone: Work_____ Home_____

Parent/Guardian Signature_____ Date_____
Student's Signature (if student possess')_____Date_____
Nurses' Signature_____Date_____

- This form should be used for any medication used to treat asthma, i.e. when medication is given per nebulizer.
- When signing this form for inhaler to be in office the parent is requesting and authorizing school personnel to administer medication to the child according to school policy and will submit a revised doctor's statement if any of the information is changed.