HEALTH SERVICES

SCHOOL MEDICATION PERMISSION AND INSTRUCTIONS

Parent Permission: *Date:* ____________________________

Student's Name____Birthdate:______________________

Address: ____Phone: ________________________

School: ________________________________ Grade ______ Teacher ________________________

I hereby grant permission for the above named school to supervise the medication routine prescribed below for the above named child.

DIRECTIONS:

Parent Signature ____________________________

PHYSICIAN'S DIRECTION

Name of Medication ____

Instructions ____

____

Physician Requests Teacher's Comments

_____ Yes: Please observe the following _______________________________________

____

____

____ No: Teacher's comments unnecessary.

______________________________________ Date

______________________________________ Physician Signature

Revised 8-84

AUTHORIZATION FOR ADMINISTRATION OF INHALED ASTHMA MEDICATIONS

(Use a separate authorization form for each medication)

School: ______________________________

Student's Name: ______________ ____ ______________
(First Name) (M.I.) (Last Name)

Sex: (please circle) Female Male Birthdate: ____/____/____

FOR COMPLETION BY PHYSICIAN

Physician's Name: ______________________________

Telephone Number: ______________ Fax Number ______________

Emergency Contact Number: ______________________________

Diagnosis: ______________________________

Name of Medicine: ______________________________

Form: ______________ Dose: ______________

Is the child knowledgable about his or 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 can not 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 carry and usehis/her inhaler asthma medication by him/herself.

Physician Signature: ______________________________ **Date:** ______________

FOR COMPLETION BY PARENT

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: ______________________________ **Date:** ______________