



Dede Proujansky
Executive Director

ASTHMA INHALER MEDICATION FORM

Student's Name: _____

_____ My child does not need/use an inhaler.

Parent Signature: _____ Date: _____

HEALTH CARE PROVIDER AUTHORIZATION

The above named student is under my care. I feel it is medically appropriate for the student to carry and self-administer asthma medication(s), when able and appropriate, and be in possession of inhaler medication and supplies at all times. The medication prescribed for this student is:

Name of medication: _____

Dosage/Time: _____

Possible side effects: _____

Signature of Health Care Provider: _____ Date: _____

PARENT AUTHORIZATION

_____ I authorize my child to carry and self-administer the medication described above

_____ I do not authorize my child to carry and self-administer this medication.

_____ I authorize appropriate/designated school personnel to maintain my child's medication prescribed above.

Parent Signature: _____ Date: _____

**INHALER(S) MUST BE PROVIDED TO THE SCHOOL ON THE FIRST DAY
OF THE SCHOOL YEAR.**