Asthma Inhaler Administration Authorization Form

Student's Name:			D.O.B:		School/Grade:		
Diagnosis:							
and medical pAsthma inhale use and date.	er administra rovider. For er medication	ation authorm will be n will have	orization form v given to school	will be co district ne, name	ompleted administ of medic	and signed by parent crator or school nurse. cation, directions for	
The student has the skin the following mann		dge and m	y authorization	to use an	n asthma	relieving medication	
school j Self-ad health o Student	personnel if minister asth office as nee t needs assis	medicatio hma relieveded. Parentance with	n is unsuccessf ing medication its will supply l	fully contour with according with according with according to the intermediate with a contour wi	trolling 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, me							
Physician's name:				Clinic/Phone:			
Physician's signature:				Date:			
Parent/Guardian signature				Date:			
School Administrator Authorization:				Date:			