Howard-Suamico School District

Authorization to Administer

INHALED MEDICATIONS

(Use a separate authorization form for each medication)

Student: _____ DOB: _____

School: _____ Grade: _____

FOR COMPLETION BY PHYSICIAN

Name of Medication: _____

Delivery of Medication: ☐ Inhaler ☐ Spacer ☐ Nebulizer

Dosage: _____

Administration: ☐ Daily/Scheduled. Time: _____

☐ As needed: Indication for use: _____

If needed, how soon can administration of inhaled medication be repeated? _____

Inhaled medication cannot be repeated more then: _____

Side effects/comments: _____

_____

Student is knowledgeable about his or her inhaled medication? ☐ yes ☐ no

Student demonstrates proper technique in administering inhaled medication? ☐ yes ☐ no

Student needs assistance/supervision in administer inhaled medication? ☐ yes ☐ no

I authorize student to carry and administer inhaled medication by him/herself? ☐ yes ☐ no

Physician's Name: _____

Telephone Number: _____

Fax Number: _____

_____ _____

Physician Signature: Date:

Fax completed signed form to 920-662-7900 – Pupil Services

FOR COMPLETION BY PARENT/GUARDIAN

I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.

I authorize student to carry and administer inhaled medication by him/herself? ☐ yes ☐ no

Parent/Guardian Phone #1 _____

Parent/Guardian Phone #2 _____

Parent/Guardian Name (print) _____

_____ _____

Parent/Guardian Signature: Date:

Parent: Return completed signed form to school office.