Asthma Inhaler Administration Authorization Form
Webster School District

Student's Name:_____ _____ D.O.B: _____Grade: _____

Type of Asthma Diagnosis: ____Mild Intermittent _____Mild Persistent
___Moderate Persistent ____Severe Persistent

In order for the student to receive the asthma relieving medication for asthma:

- Asthma inhaler administration authorization form will be completed and signed by parent and medical provider. Form will be given to school district administrator or school nurse.
- Asthma inhaler medication will have student's name, name of medication, directions for use and date.
- Authorization of asthma relieving medication will be updated annually.

The student has the skill, knowledge and my authorization to use an asthma relieving medication in the following manner:

____ Self-administer asthma relieving medication. Student will seek the care of the school personnel if medication is unsuccessfully controlling his/her asthma.
____ Student needs assistance with administration of their asthma relieving medication with the medication available as needed in the health office.

Drug name:	**Dosage:**	**Route:**	**Frequency:**	**Start date:**	**Stop date:**	**Side Effects:**
1.						
2.						

School personnel may contact the medical provider of the medication for clarification regarding indication for use, medication, dosage, side effects, successful and treatment failures.

Physician's name:	Clinic/Phone:
Physician's signature:	Date:
Parent/Guardian signature	Date:

School Nurse/Principle Authorization: _____Date:_____