2016-2017 MONDOVI SCHOOL DISTRICT

AUTHORIZATION FOR SELF-ADMINISTRATION
OF INHALED ASTHMA MEDICATIONS

(To be renewed annually and/or with dosage/medication changes)

Student's Name ______________________________ Birthdate____________Grade______

FOR COMPLETION BY PHYSICIAN: **State Law Requires physician signature**

Physician's Name: ______________________________Phone Number______________
Diagnosis: _____________________________________
Name of Medication: _____________________________Dose_____________________

Is the child knowledgeable about his or her asthma medication? Yes_____ No_______

Has the child demonstrated the proper techniques administering the medication?Yes____No____

Medicine is administered daily. Time______________

Medicine is administered when needed. Indications: __________________________________

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.

Physicians Signature____Date_________

FOR COMPLETION BY PARENT: **State Law Requires Parent/Guardian Signature**

Mother's Name__________________________________Home/Cell Phone #_______________
Father's Name___________________________________Home/Cell Phone # _______________
Emergency Contact: ______________________________Emergency Phone #_______________

Is the child authorized to carry and self-administer inhaled asthma medication? Yes____No____

I ask that my child be permitted to self medicate as authorized by my child's physician. Authorization is hereby granted for the release this information to the appropriate health care providers and/or school staff as needed for health and /or safety reasons.

PARENT/GUARDIAN SIGNATURE________________________________Date___________