

2018-2019 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 _____