St. Paul's Lutheran School

Asthma Inhaler Administration Authorization Form

Student's Name: _____ D.O.B: _____School/Grade: _____

Diagnosis: _____

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

- Asthma inhaler administration authorization form will be completed and signed by office administrator.
- 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.

____ Self-administer asthma relieving medication with access to another inhaler in the school office as needed. Parents will supply school office secondary inhaler.

____ Student needs assistance with administration of their asthma relieving medication with the medication available as needed in the school office.

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

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

School Administrator Authorization: _____ Date: _____