Asthma Inhaler Administration Authorization Form

Our Savior Lutheran School

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Our Savior
LUTHERAN CHURCH & SCHOOL

Student's Name: _____ D.O.B: _____ 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 parent and!! medical provider. Form will be given to school principal or school office.

• 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 health office as needed. Parents will supply health office secondary inhaler.
_____ 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:**

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 Administrator Authorization: _____ Date: _____