Clear Lake School District
Asthma Inhaler Administration Authorization Form

Student Name: _____ Allergies: _____

School Year:_____ DOB:_____ Grade:_____

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

____ Self-administer asthma relieving medication. The 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 inhalers.
____ Student needs assistance with administering their asthma relieving medication with the medication available in the health office.

Drug name:	Dosage:	Route:	Frequency:	Time(s)	Start date:	Stop date:	Side Effects:
1.		inhaler					
2.		inhaler					

I hereby give permission for school personnel to administer the medication(s) listed on this sheet to my child according to the practitioner and/or my instructions. I authorize them to contact the practitioner for a question or concern. I further authorize the practitioner to render treatment to my child, as appropriate and necessary, from administering the medication.

Parent/Guardian Name: _____ Phone Number:_____

Signature: _____ Date:_____

Practitioner Information:

Practitioner Name: _____ Clinic: _____

Practitioner Signature:_____Date: _____ Phone: _____

School Nurse Authorization: _____ Date: _____