Clear Lake School District
Asthma Inhaler Administration Authorization Form

Student Name: ____________________ Allergies: __________________

School: _____________ School Year:__________ DOB:______________ Grade:___________

For the student to receive the asthma-relieving medication for asthma:

- The asthma inhaler administration authorization form will be completed and signed by the parent and medical provider. The form will be given to the school district administrator or school nurse.
- Asthma inhaler medication will have the 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 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.							
2.							

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: ___________________