# School District of Crandon

# ASTHMA INHALER ADMINISTRATION FORM

**All portions of this medical request form must be completed before medications can be administered by school district personnel.**

**Student Name:** _____ **DOB:** _____
**School:** _____ **Grade:** _____ **Teacher:** _____

**Name of Medication:** _____

**Dosage:** _____ **Time(s) to be given:** _____ ☐ **a.m.** ☐ **p.m.**

**Route of Administration:** _____

**Diagnosis for which medication is to be given:** _____

**Date of discontinuation:** _____

**Explain possible reactions:** _____

**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 school personnel if medication is unsuccessful at controlling their asthma.**

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

**Prescribing Physician:** _____ **Physician's Phone #:** _____

**The School District of Crandon personnel have my permission to administer this medication as indicated above. I agree to hold the School District of Crandon, its employees or agents who are acting on this request, harmless in any and all claims arising from the administration of this medication at school. I also agree to inform the school immediately and in writing of any change in the medication order.**

**I further give permission to the school authorities to contact my child's provider if necessary.**

Parent/Guardian signature: _____ Date: _____

Home Phone Number: _____ Work Phone Number: _____

## PHYSICIAN AUTHORIZATION

The physician whose signature follows hereby authorizes school personnel to administer medication as prescribed and also agrees to accept communication regarding the administration procedures. It is understood that the medication will be given by non-licensed, but specially trained personnel.

Physician's Signature: _____ Date: _____