Milwaukee Seventh-day Adventist School
Asthma Inhaler Administration Authorization Form
(Last updated 7-1-19)

Student's Name:_______________________________________ D.O.B: ___________School/Grade: _______

Diagnosis: ____

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

- An asthma inhaler administration authorization form will be completed and signed by parent and medical provider. Form will be given to school principal or designated medication administrators.
- 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 (**Medical Provider** to check all that apply):

____ Self-administer asthma relieving medication before exercise to prevent the onset of asthmatic symptoms or uses the inhaler to alleviate asthmatic symptoms. Student may keep on his or her person while at school. 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 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.						

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: _______________