AMERICAN LUNG ASSOCIATION®

Authorization for Administration of Inhaled Asthma Medication

(Use a separate authorization form for each medication)

School:_____
Student's Name: (First/MI/Last) _____

Sex: (please circle) Female Male Birthdate: ____/____/____

FOR COMPLETION BY PHYSICIAN, NURSE PRACTITIONER, OR PHYSICIAN'S ASSISTANT:

Physician's Name: _____
Telephone Number: _____ Fax Number:_____
Emergency Contact Number:_____
Diagnosis:_____
Name of Medicine:_____
Form:_____ Dose:_____

Is the child knowledgeable about his/her asthma medication? ❑ Yes ❑ No
Has the child demonstrated the proper technique in administering medication? ❑ Yes ❑ No
Medicine is administered daily. Time:_____ ❑ Yes ❑ No
Medicine is administered when needed. Indications:_____
_____
If needed, how soon can administration of medicine be repeated?_____
The medication cannot be repeated more than_____
Side effects:_____
_____
Comments:_____
_____

( ) I have instructed _____ in the proper way to use his/her inhaled asthma medications. It is my professional opinion that he/she should be allowed to carry and use this inhaled medication by him/herself.

( ) It is my professional opinion that _____should not be allowed to carry and use this inhaled medication by him/herself.

Physician Signature/Date:_____

FOR COMPLETION BY PATIENT

Mother's Name:_____
Father's Name:_____
Mother's Work Telephone:_____ Father's Work Telephone:_____
Home Telephone:_____ Emergency Number:_____

Is the child authorized to carry and self-administer inhaled asthma medication? ❑ Yes ❑ No

As the parent of the above named student, I ask that assistance be provided to my child in taking the medicine(s) indicated above at school by authorized staff. If self-medicating is allowed or if no authorized staff member is available, I ask that my child be permitted to self-medicate as authorized by myself and my physician. Authorization is hereby granted to release this information to appropriate school personnel and classroom teachers.

Parent/Guardian Signature and Date:_____