

WALLINGFORD  SWARTHMORE
SCHOOL DISTRICT

PARENT/DOCTOR AUTHORIZATION TO CARRY OWN ASTHMA INHALER

Date _____

_____ has been instructed in the proper use of _____
(Student Name) (Name of Medication)

We, _____ and _____, request that
(Physician) (Parents/Guardians)

he/she be permitted to carry the inhaler on his/her person or to keep same in his/her locker or P.E. locker, as we consider him/her responsible. He/She has been instructed and understands the purpose and appropriate method and frequency for use of this medication. Student is also aware that the inhaler is intended for his/her use only and not to be shared with others. Violation of this policy shall result in immediate confiscation of the inhaler and loss of the privilege to self-administer. **We hereby relieve the school and its employees of any responsibility for the benefits or consequences of the medication and acknowledge that the school bears no responsibility for ensuring that the inhaler is used.**

Please note: Elementary students must check in with nurse after each use of inhaler. All students must report to nurse, if there is no resolution of symptoms.

Please complete the following information:

Diagnosis: _____

Name of Medication: _____ Dose: _____

If Medication is to be taken **DAILY**, at what time? _____

If Medication is to be taken **WHEN NEEDED**, describe indications: _____

How soon can it be repeated? _____

Is student authorized to self-medicate? _____ YES _____ NO

List significant side effects: _____

Date to stop medication: _____

Emergency response protocol:

1. _____
2. _____
3. _____

(Physician signature)

(Parent/Guardian signature)

(Physician phone number)

(Parent/Guardian phone number)