Authorization of Asthma Medication

Student Name: _____Grade: _____ Teacher: _____

Physician: _____Phone: _____ Fax: _____

Only those medications that are medically necessary during school hours or written in an IEP should be sent to school.

Taylor ISD requires the following:

- Parent/Guardian written permission for inhaler administration.
- Asthma medication must be in the **original container and properly labeled.**
- Inhaler must NOT be expired.
- The first dose of this medication **may not be given at school.**

Medication Name and Strength	Dosage	Times to be given at school	Type of Spacer	Reason for Medication to be given

Medication Start Date: _____ Medication Stop Date: _____

- I request that the above medication be given during school hours as prescribed.
- I request that this also be given on field trips as prescribed.
- I will notify the school of any change in the medication.
- I give permission for the school nurse to communicate with the student's teachers about the student's health condition and actions of the medication.
- I give permission for the school personnel to assist the student with the inhaler.
- My child _____ **may/may not** carry the medication home when the school year ends.

Parent/Guardian: _____ Date: _____Phone: _____

IF YOU WANT YOUR STUDENT TO CARRY HIS/HER INHALER

Please sign below, giving the school permission to allow your child to carry their own inhaler and self -administer.

Parent: _____Date: _____

PHYSICIAN AUTHORIZATION:

- Student is knowledgeable about the asthma inhaler and understands how and when to use it safely.
- Student may administer the inhaler without supervision.
- Student is not approved to self- medicate.

Physician's Printed Name: _____Phone: _____

Physician's Signature: _____Date: _____