Lisbon Regional School
Authorization for Administration of Inhaled Asthma Medication

American Lung Association

Student's Name: (First/Last) _____ Birthdate: ____/____/____ Grade:_____

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

Physician's Name: _____

Telephone Number: _____ Fax 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 <u>be allowed</u> to carry** and use this inhaled medication by him/herself.

( ) It is my professional opinion that _____ **should <u>not be allowed</u> 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: _____Date: _____