

AUTHORIZATION TO ADMINISTER INHALER

PART I: TO BE COMPLETED BY PARENT/GUARDIAN:

I **DO** ___ **DO NOT** ___ request that Linton Hall School permit the student identified below to carry an inhaler on his/her person in school and be allowed to use it as soon as an asthmatic attack begins. I agree to release, indemnify, and hold harmless Linton Hall School, staff and agents from lawsuit, claim demand or action related to this medication use.

Before allowing the student to carry the inhaler, the physician will review proper use with the student. The physician must complete and sign Part II stating that the student demonstrates proper knowledge before the student will be allowed to carry the inhaler.

Student: _____ Birth date: _____

Parent/Guardian Signature: _____

Printed Name: _____

Telephone Numbers: _____
(Home) (Work/Emergency)

PART II: TO BE COMPLETED BY PHYSICIAN:

Diagnosis: _____

Date of order: _____ Medication Name: _____

Duration of order (not to exceed current school year): _____

Time interval for repeating dose: _____

Symptoms or conditions for which medication is ordered: _____

List other medications that student is taking: _____

I **DO** ___ **DO NOT** ___ believe that this student has received adequate education on how and when to use the inhaler and to carry it on their person in school.

PHYSICIAN NAME: _____
(Signature) (Print/stamp)

Telephone: _____ Date: _____

PART III: TO BE COMPLETED BY ADMINISTRATOR:

Check as appropriate:

- ___ Part I and II above completed with all information.
- ___ Medication is properly labeled.
- ___ Medication label and dosage match physician order.
- ___ I have reviewed the proper use of the inhaler with the student.
- ___ Agree ___ Disagree that this student should carry their inhaler.

Administrator signature: _____ Date: _____