AUTHORIZATION FOR SELF-CARRY & ADMINISTRATION OF ASTHMA INHALER

Student's Last Name	First Name	Middle Initial	Date of Birth: month/day/year

Name of School	Teacher's Name & Room Number	Grade

In order for your child to carry inhaler on his/her person, the following must be understood and agreed upon by the student, parents and physician:

The student may utilize the prescribed inhaler as needed and directed by his/her physician. It is understood that the student has been trained and has demonstrated knowledge of proper use of the prescribed inhaler. The inhaler must be properly labeled with the student's name. BOTH THE SELF-ADMISTRATION OF PRESCRIBED MEDICATION FORM AND THIS PROTOCOL must be signed by physician and parents and placed on file at the school prior to your child carrying an inhaler on his/her person.

No direct monitoring will be conducted by the school staff. The student is responsible for self-administration of the inhaler and/or may submit a log of its use to the appropriate school staff. (The school staff is only responsible for recording on the medication log after the student states use.) If the student continues having difficulty breathing after reporting use of the inhaler, the parents will be notified by the appropriate school staff.

It is the parents' responsibility to immediately notify the school if the child's health status changes, or when a change in physician and/or medication occurs. Changes in procedure must be received in writing from the physician authorizing treatment.

The district is not responsible for any risk involved with improper handling off this medication including: overuse, improper administration, breakage, theft, loss, sharing, playing with, or careless storage of the inhaler.

Reevaluation of the present protocol may be needed if the student is found to display behavior that increases the safety risks of himself/herself or other students on campus.

Parent Signature	Authorized Health Care Provider's Name (printed)
Student Signature	Authorized Health Care Provider's Signature

MD/DO/DDS/PA/NP CA License # _____

Supervising Physician's Name/address/Phone # (if applies)

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This form must be renewed at the beginning of each school year.