KING PHILIP REGIONAL SCHOOLS
MEDICATION ADMINISTRATION IN SCHOOL
Authorization For Carrying Of Inhaler By Student

Student: _____

D.O.B.: ___/___/___ Grade: _____

TO BE COMPLETED **BY PHYSICIAN**:
I feel that it is in my patient's best interest to carry an inhaler on his/her person during the school day.
Diagnosis: _____
Medication: _____
Dose: _____
Time and method to be taken during school: _____
_____
Possible side effects and adverse reactions:
_____
The above named student has been adequately trained in correct use of the inhaler.

PHYSICIAN SIGNATURE: **X**_____
DATE: _____

TO BE COMPLETED **BY PARENT/GUARDIAN**:
I understand and agree that :
1. The inhaler will be furnished by me.
2. My child is to be the only person responsible for administering the inhaler at the time and in the dosage prescribed by the physician.
3. The inhaler must be labeled by the pharmacy with the name of the student, type of medication, dosage, and date prescribed.
4. My child has been trained adequately in the correct use of the inhaler.
5. School personnel do not assume any responsibility regarding dosage, loss of, and/or administration of the inhaler.

PARENT/GUARDIAN SIGNATURE: **X** _____
DATE: _____