



Asthma Inhaler Administration Authorization Form

Student's Name: _____

Date of Birth: _____

In order for the student to receive the asthma relieving medication for asthma:

- Asthma inhaler administration authorization form will be completed and signed by parent and medical provider. Form will be given to the main office for administrator approval.
- Asthma inhaler medication container will have affixed a label reciting the student's name, name of medication, prescribing physician's name, and directions for use and date.
- Authorization of asthma relieving medication will be updated annually or when changes are made to administration (i.e. dose, frequency, instructions for use, etc).

The student has the skill, knowledge and my authorization to use an asthma relieving medication in the following manner [check one]:

- Self-administer asthma relieving medication. Student will seek the care of school personnel if medication is unsuccessfully controlling his/her asthma.
- Self-administer asthma relieving medication with access to another inhaler in the main office (or other designated place) as needed. Parents will supply main office secondary inhaler.
- Student needs assistance with administration of their asthma relieving medication with the medication available as needed in the main office (or other designated place).

Drug name:	Dosage:	Route:	Frequency:	Start date:	Stop date:	Side Effects:
1.						
2.						

Under Wisconsin Statute Section 118.29, private schools are required to have permission from a medical provider to administer medications at school. School employees are hereby authorized to contact the medical provider and parent with questions regarding the medication administration including clarification regarding dosage, side effects or indication of the medication(s) listed above.

Physician's name:	Clinic/Phone:
Physician's signature:	Date:
Parent/Guardian signature	Date:

School Administrator Authorization: _____ Date: _____