2023-2024 MONDOVI SCHOOL DISTRICT

AUTHORIZATION FOR <u>SELF-ADMINISTRATION</u>
OF INHALED ASTHMA MEDICATIONS

(To be renewed annually and/or with dosage/medication changes)

Student's Name _____ Birthdate_____Grade_____

<u>FOR COMPLETION BY PHYSICIAN: ****State Law Requires physician signature****</u>

Physician's Name: _____Phone Number_____
Diagnosis: _____
Name of Medication: _____Dose_____

Is the child knowledgeable about his or her asthma medication? Yes_____ No_____

Has the child demonstrated the proper techniques administering the medication?Yes____No____

Medicine is administered daily. Time_____

Medicine is administered when needed. Indications: _____

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 be allowed to carry and use this inhaled medication by him/herself.

Physicians Signature_____Date_____

<u>FOR COMPLETION BY PARENT: ****State Law Requires Parent/Guardian Signature****</u>

Mother's Name_____Home/Cell Phone #_____
Father's Name_____Home/Cell Phone # _____
Emergency Contact: _____Emergency Phone #_____

Is the child authorized to carry and self-administer inhaled asthma medication? Yes____No____

I ask that my child be permitted to self medicate as authorized by my child's physician. Authorization is hereby granted for the release of this information to the appropriate health care providers and/or school staff as needed for health and /or safety reasons.

PARENT/GUARDIAN SIGNATURE_____Date_____