Lawton Public Schools

ASTHMA MEDICATION AUTHORIZATION FORM

Every effort should be made to give medicines at home as giving it at school can cause a disruption in the student's school day. If, however, your physician does order medicine to be taken during the regular school day, compliance with the following instructions is required:

Student Name _____School_____

Grade_____DOB_____ Address_____

Parent # 1 Name_____ Parent # 2 Name_____

Home Phone_____Cell Phone_____Work Phone_____

Physician's Name _____ Phone Number_____

TO BE COMPLETED BY THE PARENT/GUARDIAN

This form must be completed by a parent or guardian before a prescription medication can be administered by a designated school employee. A new form must be completed for each change in medication and renewed each school year.

It is recommended to have your pharmacist prepare an additional inhaler for school use properly labeled with the child's name, medication, dosage, frequency, directions for administration, doctor's name, prescription number, name and address of the pharmacy and date of filling. Any medication not properly labeled will not be given.
The physician instructions (on back) must match the prescription bottle before the medication can be given at school. Medications are not to be shared while at school.

******According to LPS policy, parent/guardian must transport medications to school. Do not send medications with your child.**

I, the undersigned parent/guardian, have read and understand the instructions listed above and request that a designated school employee administer to my child the following medication (the directions below must match the physicians instructions on back).

Medication Name _____ Dosage_____ mg

Frequency: ☐ Inhaler _____ puffs every _____ hours as needed

☐ Nebulizer _____ vials every _____ hours as needed

Length of time to be given ☐ Entire school year ☐ Specific time period _____

Parent Name (please print) _____ Date _____

Parent Signature _____

TO BE COMPLETED BY THE PHYSICIAN

Student's Name_____

Diagnosis for which Medication is given: ☐ Asthma ☐ Other _____

Medication Name: _____ (Inhaler) Dosage: _____mg

Medication Name: _____ (Nebulizer) Dosage: _____mg

Frequency: ☐ Inhaler_____ puffs every _____ hours as needed

☐ Nebulizer _____ vial every _____ hours as needed

Repeat if not improved in _____ minutes.

If needed, medication should be given _____ minutes prior to exercise. (P.E., Recess, Sports)

Relevant side effects: ☐ None expected ☐ Specify _____

Length of time to be given: ☐ Entire school year ☐ Specific time period_____

*** This form is **not** to be used for self administering asthma medication (Use form #3).

Other information: _____

_____

_____

***** Required *****

Physician Signature: _____

Physician Name/Title: _____ (Please print or type)

Date: _____

Telephone: _____ Fax: _____

Address: _____