HOLY ANGELS CATHOLIC
ELEMENTARY SCHOOL
230 North 8th Avenue • West Bend, WI 53095
(262) 338-1148 www.has.pvt.k12.wi.us

Authorization for Administration of Inhaled Asthma Medications

Student's Full Name ________________________

Sex ☐ Male ☐ Female Date of Birth ___/___/___

For Completion by Physician

Physician's Name ________________________

Telephone Number ( ) Fax Number ( ) Emergency Number ( )

Name of the Medication ________________________

Form ____________ Dose ____________

Is the child knowledgeable about his/her asthma medication? ☐ Yes ☐ No

Has the child demonstrated the proper technique in administering medication? ☐ Yes ☐ No

Medicine is administered daily ☐ Yes ☐ No If yes, what time ____________

Medicine is administered as needed. ☐ Yes ☐ No If yes, what are the indications ____________

If needed, how soon can administration of medicine be repeated? ____________

The medication can not be repeated more than ____________

Side effects: ________________________

Comments: ________________________

☐ I have instructed ___(insert child's name)___ in the proper way to use his/her inhaled asthma medication.
It is my professional option that he/she should be allowed to carry and use this inhaled medication by him/herself.

☐ In my professional option ___(insert child's name)___ should not carry/administer the inhaler asthma medication by him/herself.

____

Physician's Signature Date

For Completion by Parent

Mother's Name ________ Mother's Phone Number ( ) Mother's Work Phone ( )

Father's Name ________ Father's Phone Number ( ) Father's Work Phone ( )

Emergency Contact Name ________ Primary Phone Number ( ) Alt. Phone Number ( )

Is the child authorized to carry and self-administer inhaled asthma medication? ☐ Yes ☐ No

As a parent of the above named student, I ask that assistance be provided to my child in taking the medication indicated above at school by authorized staff. If self-medicating is allowed or if no authorized staff member is available, I ask that my child be permitted to self-medicate as authorized by the child's physician and myself. Authorization is hereby granted to release this information to any appropriate school personnel and teachers who interacts with my child.

I furthermore absolve Holy Angels School, its employees, agents and officers of any responsibility in safeguarding my child's inhaler or in the use/misuse of the inhaler.

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Parent/Guardian Signature Date

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Administrator's Signature Date