



## 2010-11 Inhaled Medication Form

Student's Name \_\_\_\_\_ DOB \_\_\_\_\_ Grade \_\_\_\_\_

### To be completed by Parent

I am the parent/guardian with legal custody of the above named student. I have read and understand the medication policy. I understand that the school employees and agents shall incur no liability as a result of any injury arising from the self-administration of medication by my child. I agree to abide by the medication policy and one of the following options (one must be initialed):

\_\_\_\_ I request my child be allowed to carry and self-administer the physician –ordered medication listed below. I understand my child and I are responsible for safeguarding the carried medication. I agree to provide the school with an additional supply of the medication ordered below, which can be administered by the school or my child in the event my child does not have his/her self-carried medication.

\_\_\_\_ I request a designated school employee administer my child's medications. I understand I will be notified if a school employee administers this medication.

\_\_\_\_\_  
Parent/guardian signature

\_\_\_\_\_  
Date

### To be completed by Physician

Student's Name \_\_\_\_\_ Diagnosis \_\_\_\_\_

Medication Orders \_\_\_\_\_  
\_\_\_\_\_

One of the following options must be checked:

\_\_\_\_ In my professional opinion, it is medically necessary this student be allowed to carry and self-administer the above medication. I verify that this student has the knowledge and skills to safely administer and safeguard this medication.

\_\_\_\_ I authorize this medication to be administered by a designated school employee.

Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_

\_\_\_\_\_  
Physician's signature

\_\_\_\_\_  
Date