

**Cloverdale Community School Corporation**  
**Asthma Inhaler Administration Authorization Form**

**Student's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Grade Level:** \_\_\_\_\_

In order for the student to receive asthma relieving medication:

- Asthma inhaler administration form will be completed and signed by parent and medical provider.
- Asthma inhaler medication will have the student's name, name of medication, directions for use and date.
- Authorization of asthma relieving medication will be updated annually.

**The student has the skill, knowledge and authorizations from parent and physician to use the asthma inhaler in the following manner:**

\_\_\_\_\_ Self-administer independently. Student will seek the care of school personnel if the medication is unsuccessfully controlling his/her asthma. The student may carry the inhaler and use as directed.

**\*A doctor's order must be on file stating that the student is to self-administer**

\_\_\_\_\_ The inhaler will be kept in the nurse's office. The student will go to the nurse when he/she needs to use the inhaler.

Inhaler Type:	Dosing Instructions:

Prescribing Physician's Name: \_\_\_\_\_

**\*Parent needs to request that the physician's office will fax a doctor's order/allergy plan to the school nurse at (765) 795-4339**

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

School Nurse Signature: \_\_\_\_\_ Date: \_\_\_\_\_