

THE SCHOOL DISTRICT OF GREENVILLE COUNTY
PHYSICIAN'S AUTHORIZATION FOR INHALER AT SCHOOL

PARENTAL AUTHORIZATION MUST BE PROVIDED

STUDENT'S NAME: _____ BIRTH DATE: _____

NAME OF MEDICATION: _____

OF INHALATIONS AND TIME INTERVALS: _____

PHYSICIAN MUST INITIAL ONE OF THE FOLLOWING:

Physician's
Initials

This student is allowed to self-administer this medication while at school and understands the implications of doing so. He/She has demonstrated competency in self administration of this medication. The parents are aware that they can not hold the School District responsible for any adverse outcome of this action.

OR

Physician's
Initials

This student does not need to have his/her inhaler with them at school. He/She should go to the Health Room for administration of this medication by the Nurse or designated School District employee.

Please list this student's known asthma triggers: _____

Other treatment to be used in case of severe attack: _____

Possible adverse reactions and interventions: _____

I have seen this child and agree with all the information provided on this authorization form.

PHYSICIAN'S SIGNATURE

INITIALS

DATE

OFFICE ADDRESS

OFFICE PHONE