Form Med - 1ad 05-06

PARENTAL PERMISSION FOR INHALER

****PHYSICIAN'S AUTHORIZATION MUST BE PROVIDED****

STUDENT'S NAME: ______________________ **BIRTH DATE:** ____________

PARENT/GUARDIAN: ____

HOME PHONE: ______________________ **WORK PHONE:** ______________

NAME OF INHALER: ____

PRESCRIBED BY: __________________________ **PHONE:** ____________

 # OF INHALATIONS AND TIME INTERVALS: ____________________________

PLEASE INITIAL ONE:

[ ] Parent's Initials — I request that my child be allowed to self administer and self monitor this medication at school. I have met with our physician and have determined this will provide the best medical treatment for my child. My child has been trained by the physician and demonstrated competency in this procedure. I realize that the School District of Greenville County can not be held responsible for any adverse outcome of this action.

[ ] Parent's Initials — My child does not need to carry inhaler, it should be available in the Health Room.

Other helpful information concerning your child's asthma: ______________________

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I understand that this medication must be furnished by me. If the inhaler is to be with my child at all times, I release the school from any responsibility concerning misplacement, theft, or misuse of this medication. I will notify the school immediately in writing if the medication has been discontinued or dosage has changed. I hereby give the School Nurse my permission to contact the above named Physician's office to request medical information concerning my child. I also give the School Nurse my permission to share this information with individuals who have responsibility for my child.

______________________________ ______________ ____________

SIGNATURE OF PARENT/GUARDIAN **INITIALS** **DATE**