MED-5

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