Linton Hall School

AUTHORIZATION TO ADMINISTER INHALER

PART I: TO BE COMPLETED BY PARENT/GUARDIAN:

I **DO** ____**DO NOT** ____ request that Linton Hall School permit the student identified below to carry an inhaler on his/her person in school and be allowed to use it as soon as an asthmatic attack begins. I agree to release, indemnify, and hold harmless Linton Hall School, staff and agents from lawsuit, claim demand or action related to this medication use.

Before allowing the student to carry the inhaler, the physician will review proper use with the student. The physician must complete and sign Part II stating that the student demonstrates proper knowledge before the student will be allowed to carry the inhaler.

Student: ____Birth date: _________________________

Parent/Guardian Signature: ____

Printed Name: ____

Telephone Numbers: ____

(Home) (Work/Emergency)

PART II: TO BE COMPLETED BY PHYSICIAN:

Diagnosis: ____

Date of order: ________________________ Medication Name: ____________________________________

Duration of order (not to exceed current school year): ____

Time interval for repeating dose: ____

Symptoms or conditions for which medication is ordered: ____

____

List other medications that student is taking: ____

I **DO**____ **DO NOT**____ believe that this student has received adequate education on how and when to use the inhaler and to carry it on their person in school.

PHYSICIAN NAME: ____

(Signature) (Print/stamp)

Telephone: ____ Date: _____________________________

PART III: TO BE COMPLETED BY ADMINISTRATOR:

Check as appropriate:

____ Part I and II above completed with all information.

____ Medication is properly labeled.

____ Medication label and dosage match physician order.

____ I have reviewed the proper use of the inhaler with the student.

____ Agree ____ Disagree that this student should carry their inhaler.

Administrator signature: ________________________________ Date: ____________________________