BIO-MED
SCIENCE ACADEMY

Inhaler Permission Form

All sections must be complete. Completed form must be submitted to the Executive Director or his/her designee and the School Nurse, if the school has one assigned.

To be completed by the Physician:

Name of Student: ____

Student Address: ____

The above-named student has the approval to possess and use the following inhaler medication to alleviate asthmatic symptoms. Use must be according to the following specifications:

Name and dose of medication: ______________________________________

Date the administration of the medication is to begin: __________________________

Date, if known, administration of medication is to cease: ________________________

The following procedure is to be employed in the event that the medication does not produce the expected relief from an asthma attack:

____

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Please list any severe adverse reactions that may occur to the student using the inhaler that should be reported to the physician:

____

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Please list any severe adverse reactions that may occur to another student, for whom the inhaler is not prescribed, should such student receive a dose of the medication:

____

____

Any other special instructions:

____

____

Physician Signature: ____

Physician Name (Printed):______________________________________

Physician Address: ____

Emergency Telephone Number: __________________________________

To be completed by a Parent or Legal Guardian

Name and emergency telephone number of a parent or guardian or other person having care or charge of this student in an emergency:

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I, as the parent or legal guardian of the above-named student, do hereby give my approval for this student's possession and use of the inhaler medication described above.

Parent/Guardian Signature: ______________________________

Parent/Guardian Name (Printed):______________________________

Date: ____________________