Mayfield City School District

Gates Mills♦Highland Hts.♦Mayfield Hts.♦Mayfield Village

Authorization for Self-Administration of Asthma Inhalers While on overnight school trip

The following section is to be completed by the **PARENT:**

School: _____ Grade: _____ Date: ___/___/___

Student's Name: _____ D.O.B.: ___/___/___ has been instructed in and understands the purpose, proper method, and appropriate frequency of using an inhaler. I request that my child be permitted to carry an inhaler as I consider him/her responsible in using it. My child knows that the inhaler is for his use only and is to be kept with his belongings. (on his person or bag)

I will provide the inhaler and the appropriate prescription information. I understand that self-administration will be revoked if any problem arises with the medication use. I, the undersigned, absolve Mayfield Schools of any responsibility regarding the use of my child's inhaler. I have read and agree to follow the school medication policy.

Parent/Guardian name: _____ Phone: (Work): (____)_____

(Home): (____)_____

Parent/Guardian Signature: _____ (other): (____)_____

The following section is to be completed by **HEALTHCARE PROVIDER** prescribing the inhaler:

Student's Name: _____ has been instructed in and understands the purpose, proper method, and appropriate frequency of using an inhaler, and is capable of self-administration.

Drug name: _____ Dosage: _____

Length of time medication is to be given: Start Date: ____/____/____ Stop Date: ____/____/____

Potential adverse reactions to be reported by Physician: _____
_____

Procedures to follow when inhaler does not produce expected relief from attack: _____
_____

Other special instructions: _____

_____ Phone: (____)_____
(Physician's name-please print)

_____ Date: _____/_____/_____
(Physician's signature)

Revised: 4/16