Wissahickon School District

True Blue with a Heart of Gold

Inhaler Medication: Self-Administration Authorization

Parent/guardian request for self-administration of inhaler during school hours and acknowledgement that District Policy 210.1 applies to this signed permission.

Student Name and Grade: _____

Medication to be Given: _____

Medication Dose and Frequency: _____

Reason for Medication: _____

This student has received asthma education in my office regarding the safe handling of the above medication and may do so in school and at school-related activities.

_____

(Physician Signature) (Telephone Number) (Date)

_____

(Parent/Guardian Signature) (Telephone Number) (Date)

We request that students report to the nurse after the inhaler is used to determine the effectiveness of the medication District Policy 210.1 is available on the District website at www.wsdweb.org