Contoocook Valley School District
Inhaled Medication Administration Form (Self Administration)

Student's Name:____ DOB: ____________________________

Student's Teacher____Grade:_________________________________

Parent/Guardian Name: ____ Emergency Tel#________________________

Name of Medication:____

Please list all medications student is taking at home (Prescription and Over-the Counter medications):

____

____

To be completed by health care provider:

Diagnosis/Condition:______**Asthma**____

Please list any other medical conditions requiring medication, if not a violation of confidentiality or if not contrary to the request of parents/guardian to keep confidential:

____

DOSE to be given @ school and ROUTE:____

FREQUENCY and TIME (s) to be given @ School:____

Specific recommendations for administration: ____

Special side effects, contraindications and adverse reactions of this medication to be observed for:

____

Dates to be given at school ____________________________________ or **this school year**

It is my professional opinion that _________________________________ has the knowledge and skills to safely possess and use an inhaler in school and should be allowed to carry and use that medication by himself/herself without supervision.
(Circle One) Yes No

Lic. Prescriber's Signature: _____________________________________Date: ___________________________

Lic. Prescriber's Name (please print):____

Business Telephone:_________________________ Emergency Telephone:_____________________________

PARENT/GUARDIAN AUTHORIZATION

Yes No I give my permission for release/exchange of pertinent information between the school nurse and the lic. prescriber's office by telephone, mail or electronic exchange regarding all of the above medical/ medication information concerning my child.

Yes No I give my permission for other school personnel to be notified of the medication and any adverse effects.

Signature of Parent/Guardian____ Date: _______________________

My child has been instructed in the proper way to use his/her medications and should be allowed to carry and use that medication by himself/herself without supervision and I give my child permission to do so.

Signature of Parent/Guardian ____Date: __________________

Parent will provide backup inhaler to be kept in Health Office YES NO ____________
Parent initials

2-11-08