Authorization for Inhaler

St. Joseph School, Brookfield, CT 06804

Connecticut State Law requires a MD, APRN, or PAC written order and a parent/guardian authorization for medications to be used in school (self-administered or administered by school personnel).

Prescriber's Orders

Child's name_____ Grade_____ DOB_____

Condition for which drug is being administered during school hours_____

Asthma Severity: (circle) mild moderate severe exercised induced

Medication, dose, and method of administration_____

Crisis orders if different than above_____

Duration of administration: 1. For the entire school year_____ or 2. (date)_____to (date)_____

Relevant side-effects to watch for_____

Management plan for side-effects_____

Authorized Prescriber's Name (print) _____

Office phone_____ Fax _____

Authorized Prescriber's Signature _____ Date_____

To School Personnel: I hereby request that the above medication, ordered by the above MD, APRN, or PAC, for my child, be administered by school personnel.

Parent/Guardian name (print) _____ Date_____

Parent/Guardian signature_____

Phone: (H) (W) (C)

Self Carry Inhaler Permission

We, the Authorized *Prescriber and the Parent/Guardian* consider the above student responsible and request he/she be permitted to either carry or keep the inhaler in his/her locker.

(Student name)_____ has been instructed and understands the purpose, appropriate method, and frequency of use, of the inhaler. We, the undersigned, absolve the school of any responsibility in safeguarding the student's inhaler or for any untoward side-effects, should the student not use the inhaler properly while it is in his/her possession.

Authorized Prescriber_____ Date_____

Parent/Guardian_____ Date_____

School Nurse_____Date_____