

BEDFORD SCHOOL DISTRICT
ASTHMA INHALER/MEDICATION PERMISSION AND PHYSICIAN ORDER FORM

STUDENT: _____ SCHOOL: _____

DATE OF BIRTH: _____ GRADE: _____ HOME ROOM: _____

PARENT/GUARDIAN: _____ HOME PHONE#: _____

ADDRESS: _____ WORK PHONE#: _____

Asthma Medications	When Taken?	Dose/Route	To be taken at school	Adverse Reactions
1.	<input type="checkbox"/> Every day <input type="checkbox"/> For wheezing/attacks <input type="checkbox"/> Before exercise/sports <input type="checkbox"/> Certain times of year <input type="checkbox"/> When ill		<input type="checkbox"/> Yes. When? ____ <input type="checkbox"/> No	
2.	<input type="checkbox"/> Every day <input type="checkbox"/> For wheezing/attacks <input type="checkbox"/> Before exercise/sorts <input type="checkbox"/> Certain times of year <input type="checkbox"/> When ill		<input type="checkbox"/> Yes. When? ____ <input type="checkbox"/> No	
3.	<input type="checkbox"/> Every day <input type="checkbox"/> For wheezing/attacks <input type="checkbox"/> Before exercise/sports <input type="checkbox"/> Certain times of year <input type="checkbox"/> When ill		<input type="checkbox"/> Yes. When? ____ <input type="checkbox"/> No	

___ I verify that _____ has the knowledge and skills to safely possess and use asthma inhaler in a school setting.

___ I verify that _____ should not carry his/her inhaler medication by him/herself.

Prescribed by: _____ **Date:** _____
(Signature of Health Care Provider)

Name of Provider: _____ **Phone:** _____ **Providers Emergency Phone #:** _____

PARENT/GUARDIAN PERMISSION

___ I give permission for my child to possess and use his/her inhaler **OR**
 ___ I hereby authorize the designated staff person to administer the above-prescribed medication according to the directions.
 In consideration for this service, I (we) further hereby agree that I (we) will not hold liable, and will otherwise save harmless, The Bedford School District and/or any department or employee thereof for any death or injury resulting from the administration or assistance in the administration of the medication described above.

I hereby authorize that, if necessary the school nurse and above physician may share information relative to the health of my child (name) _____.

Parent/Guardian Signature _____ Date: _____
For questions, contact school nurse _____ at _____