SELF-MEDICATION REQUEST FORM
(Asthma Inhalers)
LAKE LOCAL SCHOOL DISTRICT

This portion to be completed by the Parent/Guardian

Student Name Building

School Year Grade/Teacher Date of Birth

Address

I request that my child be permitted to carry his/her metered dose inhaler while at school and for school related activities. I realize that my child will be required to have his/her inhaler on his/her person in order to go on any field trips or other extracurricular events off campus. A back up inhaler is to be kept in the school clinic. This form is valid for the remainder of this school year or until the prescribing doctor or other authorized healthcare provider discontinues this prescription/dose.

Parent/Guardian Signature *Date* *Phone (H/W/C)*

This portion to be completed by the physician or other prescribing health provider

Medication Dosage Time

Date administration of the medication is to begin: ____________________ end: ______________________

Adverse reactions that should be reported to the physician: ______________________________________

Procedure to follow in the event that the medication does not produce the expected response/relief:

This student received instruction in the use of this inhaler by myself or my trained staff. It is my recommendation that this student carry his/her inhaler on his/her person at all times.

Yes No (circle one)

Physician/Authorized Prescribing Healthcare Provider Signature *Phone* *Date*

Printed Name *Address* *Telephone*

Form AO_44 5/11