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

Student Name _____ Building _____

School Year _____ Grade/Teacher _____ Date of Birth _____

Address _____

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 in case of emergency* *Date*

Printed Name *Address* *Telephone in case of emergency*

This portion to be completed by the Parent/Guardian

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 Numbers (Home/Work/Cell) in case of emergency*