USD 217 Rolla Schools
INHALER RELEASE FORM

Date_____ Birth Date: ____/____/____ Grade_____

Student's Name_____

FOR COMPLETION BY PHYSICIAN

Physician's Name: _____

Telephone Number: _____ Fax Number: _____

Emergency Contact Number: _____

Diagnosis: _____

Name of Medicine: _____

Form: _____ Dose: _____

Is the child knowledgeable about his/her asthma medication? ❑ Yes ❑ No

Has the Child demonstrated the proper technique in administering medication? ❑ Yes ❑ No

Medicine is administered daily _____ ❑ Yes ❑ No

Medicine is administered when needed. Indications: _____

_____

If needed, how soon can administration of medicine be repeated? _____

The medication can not be repeated more than_____

Side effects: _____

Comments: _____

Please check all that apply:

❑I have instructed the above named student in the proper way to use his/her inhaled asthma medications. It is my professional opinion that he/she should be allowed to carry and use this inhaled medication by him/herself.

❑It is my professional opinion that the above named student should **not carry** and use his/her inhaled asthma medication by him/herself. If this box is checked, I authorize school staff to administer the medication named above and understand that the inhaler will be kept in the school office and will be packed in a backpack to be taken on field trips.

_____ _____ _____

Physician's Signature **Fax Number** **Phone Number**

FOR COMPLETION BY PARENT

We, the parent/guardian of the above named student, request that assistance be provided to my child in taking the medicine(s) indicated above at school by authorized staff. If self-medicating is allowed or if no authorized staff member is available, I ask that my child be permitted to self-medicate as authorized by my physician and myself. Authorization is hereby granted to release this information to appropriate school personnel and classroom teachers.

We, the parent/guardian of the above named student authorize permission for him/her to carry the inhaler on his/her person or keep same in his/her locker or desk, as we consider him/her responsible. He/she has been instructed in and understands the purpose and appropriate method and frequency of use of his/her inhaler. ❑ **Yes** ❑ **No**

The school office has been provided with a back-up inhaler: ❑ **Yes** ❑ **No**

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Work Phone: _____ Home Phone: _____