Initials: ___________

MSAD#1
Parent Request and Medical Provider Order for
Student Inhaler/Nebulizer use in School

Phone: 764-8105 FAX: 768-3085

Child's Name ________________________________ DOB ____________ Grade ____________

Allergies ____

Name of medication ____________________________ Reason for medication ________________

Time to be given ______________________________ Number of puffs ____________________

Side Effects: Dry mouth, irritated throat, dizziness, headache, light headedness, heartburn, loss of appetite, altered taste sensation restless, anxiety, nervousness, trembling, sweating may occur

CHECK ONE:

- ☐ I request that my child be assisted, at school, by an authorized person in using an **inhaler/neb** as authorized by me and my child's health care provider, if approval is given by provider's signature below.
- ☐ My child has the knowledge and skills to safely possess and use an inhaled asthma medication and I am requesting that he/she be permitted to carry and self-administer an **inhaler/neb** as authorized by me and my child's health care provider, if approval is given by their provider's signature below
- ☐ My child no longer needs to have an inhaler at school at this time. Should the need arise, I will contact the school nurse, bring in the medication and complete the appropriate paperwork at that time.

Health Care Provider's Name ____
(Please list Health Care Provider and we will fax this form to their office)

Parent/Guardian Review & Signature ______________________ Phone ___________ Date _______

Health Care Provider Review & Signature ________________________________ Date _______

The following is to be completed by the School Nurse per parent and provider request:

- ☐ The proper use of prescribed inhaler has been reviewed with student. The student demonstrates competency in the use of the prescribed inhaler per MSAD#1 Student Asthma Management Skills Competency Assessment Guidelines.
- ☐ Does not self-administer.

School Nurse Signature: ______________________________ Date: ______________________