Faxed: ____________
Initials: ____________

MSAD#1
Parent Request and Medical Provider Order for
Student Inhaler use in School –there will be NO nebulizer treatments in school this year.
STUDENT MUST HAVE A CHAMBER OR SPACER TO USE WITH THE INHALER.

Phone: 207-764-8105 FAX: 207-768-3085

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** 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** 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.

Inhaler will be kept ____

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: ______________________