Saint Thérèse of Lisieux
CATHOLIC PARISH & SCHOOL

INHALER CONSENT FORM - TO BE COMPLETED BY A PHYSICIAN

Student's Name: _____ Date of Birth: _____

Diagnosis: _____

In order for the student to use an inhaler:

- The inhaler administration authorization form will be completed and signed by a parent and a medical provider. The form will be given to the school administrator/office.
- Asthma inhaler medication will have the student's name, name of medication, directions for use and the date.
- Authorization of asthma relieving medication will be updated annually.

The student has the skill, knowledge and my authorization to use an asthma relieving medication in the following manner:

___ Self-administer asthma relieving mediation. Student will seek the care of the school personnel if medication is unsuccessfully controlling his/her asthma.

___ Self-administer asthma relieving medication with access to another inhaler in the school office as needed. Parents will supply school office secondary inhaler.

___ Student needs assistance with administration of their asthma relieving medication with the medication available as needed in the school office.

Drug Name:	Dosage:	Route:	Frequency:	Start date:	Stop date:	Side Effects:
1.						
2.						

School personnel may contact the medical provider of the medication for clarification regarding indication for use, medication, dosage, side effects, successful and treatment failures.

Physician's name:	**Clinic/ Phone:**
Physician's signature:	**Date:**
Parent/Guardian signature:	**Date:**

School Administrator Authorization: _____ Date: _____

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