Cedar Grove Belgium School District
ASTHMA INHALER ADMINISTRATION AUTHORIZATION FORM

Student Name_____

Birthdate_____ Grade_____ Teacher/HR _____

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

____ Self-administer asthma relieving medication. 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 health office as needed. Parents will supply health office secondary inhaler.
____ Student needs assistance with administration of their asthma relieving medication with the medication available as needed in the health office.

Medication	Dosage	Route	Frequency	Contraindications	Possible Side Effects

An Asthma Action Plan has been completed and accompanies this document.

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:

FAX: Elementary School 920-668-6933, Middle School 920-668-8566, High School 920-668-8605