Appendix F

SELF MEDICATION FOR ASTHMA INHALERS

(Authorization Form)

Lial Catholic School
5700 Davis Road
Whitehouse, Ohio 43571
Phone: 419-877-5167
Fax: 419-877-9385

MUST BE READ AND COMPLETED BY PARENT/GUARDIAN AND STUDENT

_____has been instructed in the proper use of
(Name of student)
_____inhaler. We request that he/she be permitted to carry this inhaler on
(Name of medication)
his/her person or keep in his/her book bag, as we consider him/her responsible. He/she has been instructed in and understands the purpose and appropriate method and frequency of use of this inhaler. He/she also understands this inhaler is not to be shared or used by others. I also understand that my child will not be monitored when using this inhaler nor will a specific record of its use be kept.

I **authorize** school personnel to allow use of this above medication to the above named child as ordered by our health care provider. I also authorize the school nurse to consult with the health care provider about my child's medication needs. I will see that my child's inhaler is properly labeled with the name of the medication and my child's name.

I understand that the student is responsible for the proper maintenance and use of the medication. I understand that if the student is found to have shared his/her inhaler with other students, or otherwise abused the medication or device, the student will not be permitted to carry his/her inhaler at school and disciplinary action may also occur. I understand, and have informed the student, that he/she must immediately notify the school bus driver, school principal, school nurse, or teacher if his/her inhaler is lost or taken from him/her by another person.

In consideration of the administration of medical services as requested and authorized by this form, I/we, or myself/ourselves, and my/our heirs, executors, administrators and assigns, do hereby waive, release and forever discharge and agree to indemnity and defend the School and the Diocese of Toledo, their members, officers, administrators, employees, servants and agents from and against all claims, demands, or causes of action by any person or entitles, for loss, cost, injury, or damage whatsoever arising from or claimed to arise from or in any way connected with the administration of authorized medical services to the student named above.

As **parents/guardians** of the child named above **I/We acknowledge that I/We have read and understand** the above statements. As the **student** named above, **I have read and understand** the above information and the responsibility I assume in keeping the above named medication on my person.

PARENT/GUARDIAN _____ _____
(Signature) (Date)

STUDENT _____ _____
(Signature) (Date)

(OVER)

Appendix F
(continued)

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INFORMATION TO BE PROVIDED BY PHYSICIAN WHEN STUDENT IS AUTHORIZED TO CARRY AN INHALER AT SCHOOL

Student's Name_____Grade_____

Student's Address _____

Name Of Medication In Inhaler: _____

Dosage And Time To Be Taken: _____

Date To Begin Administration: _____

Date To Cease Administration: _____

Specific Instructions for Use: _____

_____

ADVERSE REACTIONS, if any, that might occur to the student using the inhaler:

_____

_____

INSTRUCTIONS to follow if medication does not produce expected relief from student's asthma attack:

_____

_____

POSSIBLE ADVERSE reactions to an unauthorized user: _____

_____

The above-named student knows and understands the proper use of his/her inhaler and should be allowed to carry it on his/her person. He/she also understands this inhaler is not to be shared or used by another person.

Yes_____ No_____

Physician Name: _____

Physician's Emergency Number _____

Physician's Signature _____Date_____

A new form must be completed whenever the prescription changes and at the beginning of each school year.