MOST PRECIOUS BLOOD SCHOOL
1529 Barthold Street
Fort Wayne, Indiana 46808
260-424-4832
www.preciousblood.org

Inhaler Self-Administration

Student _____ Grade _____

To be completed by a physician/practitioner:

My patient _____ has been instructed in the proper use of his/her inhaler. The inhaler I have prescribed is _____. My patient is authorized to use the inhaler _____ times per day or as follows: _____. The prescription for the inhaler expires _____. This student's well being is in jeopardy unless the inhaler is carried on his/her person; therefore, we request that he/she be permitted to carry the inhaler. He/she understands the purpose, appropriate method, and frequency of the use of this medication.

Physician/Practitioner: _____(Stamp or Print)

Address: _____

Phone #: _____ Date: _____

Signature: _____

To be completed by Parent/Guardian:
I permit my child to carry the above listed inhaler as ordered by his/her physician/practitioner. I understand that my child, not the school, is responsible for the storage, possession, and use of the inhaler. I understand that sharing medication with other students will result in disciplinary action.

Parent/Guardian Signature: _____ Date: _____

To be completed by the Student:
I understand the purpose, appropriate method, and frequency of use of this inhaler. I understand that I, not the school, am responsible for the storage, possession, and use of the inhaler. I understand that haring medication with other students is potentially dangerous and will result in disciplinary action

Student Signature: _____ Date: _____

This form must be completed in addition to the routine medication authorization form.