

**HUNTINGDON SPECIAL SCHOOL DISTRICT
HEALTH SERVICES**

**AUTHORIZATION FOR STUDENT TO CARRY PRESCRIBED ASTHMA INHALER
OR FOR CHILD TO BE ASSISTED WITH USE OF INHALER**

If medication can be given at home or after school hours, please do so. However, if medication must be given during school hours, this form must be completed prior to school personnel distributing the specified medication.

Student's Name: _____

Homeroom Teacher: _____

Please check option 1 or option 2.

_____ OPTION 1: STUDENT CARRY PRESCRIBED INHALER

My child needs to carry the following prescription labeled inhaler with him/her so that it is immediately accessible whenever needed.

1. My child has demonstrated corrected use of the inhaler and follows prescribed medication orders.
2. My child agrees to never share the inhaler with another student or individual.
3. My child knows if there is not marked improvement after using the inhaler then he/she will go to the school office and request the school nurse.
4. I understand that the parent/guardian accepts the legal responsibility should the inhaler be lost, given, or taken by a person other than the above named student.
5. I understand the Huntingdon Special School District has no legal responsibility when the above named student administers his/her own medication.

_____ OPTION 2: STAFF MEMBER WILL KEEP AND ASSIST IN USE OF INHALER.

My child will be assisted with use of an inhaler. The inhaler will be kept with the homeroom teacher or designated teacher. The medication will be administered properly, under adult supervision, in the correct dosage, and a record kept.

Name of Medication: _____ Dose: _____

Time/Frequency of Use: _____ Stop medication on: _____

Condition/Illness requiring medication: _____

Possible Side Effects, if any: _____

Physician's Name: _____ Physician's Phone: _____

I hereby authorize the personnel, employees and officials of Huntingdon Middle School to assist my child in taking prescribed medication according to district policy. I understand that in the event of a change in medicine, I am responsible for presenting a new request form.

Parent/Legal Guardian Signature

Date

Home Phone: _____

Work Phone: _____

Pager/Cell Phone: _____