

# **Inhaler Self-Administration Consent & Release**

Student: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_

**To be completed by a physician/healthcare provider:**

My patient, \_\_\_\_\_, has been instructed in the proper use of his/her inhaler.

My patient is authorized to use the: \_\_\_\_\_

This student's wellbeing is in jeopardy unless the above inhaler is given to him/her. This patient understands the purpose, appropriate method, and frequency of the use of this medication.

Physician/Healthcare Provider: \_\_\_\_\_

Please Print or Stamp

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Healthcare Provider's Signature: \_\_\_\_\_

**To Be Completed by Parent/Guardian:**

I permit my child to be carry the above inhaler as ordered by his/her physician/healthcare provider. I understand that my child, not the school, is responsible for the storage, possession 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 the use of my inhaler. I understand that I, not the school, is responsible for the storage and possession of the inhaler. I understand that sharing this 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 and a care plan.