Spring Creek ISD

INHALER(S) ADMINISTRATION REQUEST

Date: _____ School:_____

We, the undersigned parents/guardians of _____, request that our child be allowed to keep the prescribed inhaler(s) on his/her person at all times and to self-administer medication as requested by the physician. We understand that it is the student's sole responsibility to keep the inhaler(s) on his/her person. If they are misplaced or used by other students, this privilege will be revoked. We also understand that the inhaler(s) must be properly labeled with a prescription label.

Signature of Parent/Guardian:_____

PHYSICIAN REQUEST

You are hereby authorized to allow _____ to carry the prescribed inhaler(s) on his/her person at all times and self-administer medication due to the student's asthma.

Name of Inhaler(s):_____

Dosage and Time of Administration:_____

Period for which medication will be required: _____

Signature of Physician_____