ASTHMA MEDICATION ADMINISTRATION

VALID FOR CURRENT SCHOOL YEAR ONLY

Date: _____

Student's Name: _____ **Date of Birth** _____ **Grade** ____

Asthma triggers: _____

Reason to Give Medication: _____

The above student has been diagnosed with asthma and on occasion will require the following asthma medication to be administered at school:

☐ Administration via **inhaler**:

Medication _____ Dosage: _____

☐ Administration via **nebulizer**:

Medication _____ Dosage: _____

☐ The above named student may carry and **self-administer** his/her inhaler during the school day. This student has been instructed and demonstrates the proper technique to administer his/her asthma medication.

Medication _____ Dosage: _____

Physician's Signature: _____ **Date:** _____

Parent's Signature: _____ **Date:** _____

SCHOOL OFFICE USE ONLY

☐ This form is completed and signed by both the physician and parent or guardian.

☐ Medication is in its original container and labeled with the student's name.

School Staff Signature: _____ **Date:** _____

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The Ecclesial School at Northland
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