TRINITY SCHOOL
AT MEADOW VIEW

Inhaler Authorization 2020-21

Student Name _____

Date of Birth _____

Known Allergies: _____

Part I to be completed by Parent or Guardian

I hereby request designated school personnel to administer an inhaler as directed by this authorization for the 2019 – 2020 academic year. I agree to release, indemnify, and hold harmless Trinity School at Meadow View, the designated school personnel, or agents from lawsuits, claim expense, demand or action, etc., against them for helping this student use an inhaler.

Inhaler: ____ Renewal ____ New (If new, the first full dose must be given at home to assure that the student does not have a negative reaction.) **First dose was given:** Date_____ Time_____

_____ _____ _____

Parent or Guardian Name (Print or Type) **Parent Signature** **Date**

Part II and III to be completed by a Licensed Health Care Provider (Lay language, no abbreviations)

DIAGNOSIS: _____

LIST TRIGGERS: _____

SIGNS / SYMPTOMS: _____

MEDICATION AND ROUTE: _____

DOSAGE TO BE GIVEN AT SCHOOL INTERVAL FOR REPEATING DOSAGE: _____

TIME TO BE GIVEN: _____ COMMON SIDE EFFECTS: _____

EFFECTIVE DATE: _____ Start: _____ End: _____

PART III

This patient has received information on how and when to use an inhaler and that he or she demonstrates its proper use.

Please check either a or b below:

_____ a. The patient is to carry an inhaler during school and during sanctioned events. An additional inhaler, to be used as backup, is needed at the **FRONT DESK** in an approved school medication locked box.

_____ b. It is not necessary for the student to carry his inhaler during school, the inhaler can be kept at the **FRONT DESK** in an approved school medication locked box.

_____

Licensed Health Care Provider (Print or Type)

_____ _____ _____

Licensed Health Care Provider Signature **Phone** **Date**