MUST BE SIGNED BY PHYSICIAN

MEDICATION ADMINISTRATION AUTHORIZATION

ASTHMA

2024-2025

STUDENT

Student Name:	DOB:
School:	Teacher/Grade:

MEDICATION ***(Check only those that apply)***

☐ ALBUTEROL Strength:

☐ OTHER Strength:

Asthma Triggers: ☐ Exercise ☐ Animals ☐ Mold/Pollen ☐ Food ☐ Respiratory Infection ☐ Weather Change ☐ Strong Odors/ Fumes ☐ ___________________

ROUTINE ADMINISTRATION	AS NEEDED ADMINISTRATION	EMERGENCY
_________ puffs 15 minutes prior to exercise (PE or athletics)	__________ puffs as needed for ☐ coughing ☐ wheezing ☐ chest tightness ☐ other ________________________________ ☐ May repeat in 20 minutes if symptoms not improved, for a total of _____ treatments.	______________ puffs as needed for ☐ nostrils flaring ☐ rib retractions ☐ trouble walking/talking ☐ lips or nails gray/bluish ☐ if as needed treatments did not improve symptoms ☐ other ____ ***CALL 911 IMMEDIATELY***

HEALTH CARE PROVIDER

The patient is able to self-administer as ordered. ☐ Yes ☐ No

**** Student will notify school personnel immediately if medication is self-administered.****

HCP Name/Title (Print):	HCP Signature:
Telephone:	FAX:
Address: ZIP:	State:

PARENT/GUARDIAN

I request designated and trained Millwood Public Schools personnel administer medication for my child as directed by this authorization. I agree to release, indemnify, and hold harmless the school district, school personnel, employees or agents from any lawsuit, claim, expense demand or action, etc, against them for administering myself this medication.

- I understand that the prescriber will be called if a question arises about my medication as allowed by HIPAA.
- I understand that medications must be in a prescription bottle labeled with the name of the medication, name of the staff member, name of the prescriber, date and directions for administration of the medication at school.
- I understand that a new authorization form is required each school year and for any changes in the medication time or strength.
- I understand this medication cannot be given at any other time during the school day than what is prescribed above by the healthcare provider.
- I understand that the medication is to be kept in the office at school, with the exception if my child has been authorized by the healthcare provider and the school nurse to carry/self-administer the medication.
- I understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded.
- I understand that in the event of a field trip, athletic event or other activity outside of the school building, it is my responsibility to notify the teacher that this medication needs to accompany myself

Parent/Guardian Signature:	**Date:**
Phone:	**Alternate Phone:**
Nurse Approved:	**Date:**