ALEXANDRIA CITY PUBLIC SCHOOLS
AUTHORIZATION TO ADMINISTER INHALER

Name of student: _____ Birth date _____
School: _____ Grade: _____
School Year: _____

PART I: TO BE COMPLETED BY PARENT/GUARDIAN:
I DO_____DO NOT_____ request the Alexandria City Public Schools to permit the student identified above to carry an inhaler on his/her person in the school and to be allowed to use it as soon as an asthmatic episode begins.

Before allowing the student to carry an inhaler, the school nurse will review proper use with the student. The school nurse must sign that the student demonstrates proper knowledge before the student will be allowed to carry the inhaler.

I will supply medication to the school nurse and request that this medication be available in the school as prescribed by my student's physician/medical provider. I agree to release, indemnify, and hold harmless Alexandria City Public Schools, their staff and agents from lawsuit, claim demand or action related to the use of this medication.

My child **is** capable of self-administration of the inhaler - circle one (YES) (NO)

I want my child to carry the inhaler during the school day – circle one (YES) (NO)

The school nurse will release the inhaler to the ACPS staff member accompanying my child on every field trip for the current school year unless I request otherwise.

Signature: _____ Printed Name: _____
Contact Numbers: (H) _____ (W) _____ (C) _____

PART II: TO BE COMPLETED BY PHYSICIAN/LICENSED PRESCRIBER;
Diagnosis: _____
Date of order: _____ Medication Name: _____
Duration of order (not to exceed current school year): _____
Time interval for repeating dose (in a public school setting):_____
Symptoms for which medication is ordered:
_____
I DO _____ DO NOT _____ believe that this student has received adequate education on how and when to use the inhaler and to carry it on his/her person in school.
Other medication currently being taken: _____
PHYSICIAN/LICENSED PRESCRIBER NAME: _____
(Signature) (Printed/Stamped)
Physician/Licensed Prescriber contact number: _____ Date: _____

PART III: TO BE COMPLETED BY THE SCHOOL NURSE:
Check as appropriate:
_____ Part I and II listed above completed with all information
_____ Medication is properly labeled
_____ Medication label and dosage match physician's order
_____ I have reviewed the proper use of the inhaler with the student and I
AGREE _____DISAGREE _____ that the student should carry it during school hours.
_____ Expiration date _____
Nurse: _____ Date: _____
(Signature) (Printed/Stamped) Rev. 4/08