Baldwin-Woodville Area School District

AUTHORIZATION FOR ADMINISTRATION OF INHALED ASTHMA MEDICATION
(Use separate authorization form for each medication and each student)

BWSD Board Policy 453.4 – Exhibit 3

TO BE COMPLETED BY PHYSICIAN/PA/NP

Name of Student: _____Birthdate: _____ Grade: _____

Diagnosis: _____

Name of Medication: _____

Form: _____ Specific dose(s) to be given at school: _____

Is the student knowledgeable about his/her asthma medication ☐ Yes ☐ No

Has the student demonstrated the proper technique in administering the medication ☐ Yes ☐ No

Medication is administered as needed ☐ Yes ☐ No - If No, administration time is _____

If needed, how soon can administration of medication be repeated: _____

The medication can not be repeated more than: _____

Side effects of medication:_____

Comments: _____

☐ I have instructed _____ in the proper way to use his/her asthma medications. It is my professional opinion that he/she be allowed to carry and use this medication by himself/herself.

☐ It is my professional opinion that _____ should not carry and use his/her inhaled medication by himself/herself.

Printed name of MD/PA/NP: _____

Signature of MD/PA/NP: _____ Date: _____

Address of MD/PA/NP: _____

Telephone number of MD/PA/NP: _____

Parent Signature and Information

1. Is the student authorized to carry and self administer inhaled medication? ☐ Yes ☐ No
2. If No was selected in #1, I ask that assistance be provided to this student in taking the medicine indicated above by authorized BWSD staff.
3. If self administering, it is requested that this student be permitted to self-medicate as authorized by myself and the physician.
4. Authorization is granted to release appropriate information to BWSD staff.

Parent/Guardian signature:_____ Date:_____

Print Name:_____ Phone:_____