PERMISSION FOR A STUDENT TO CARRY AND SELF-ADMINISTER PRESCRIPTION METERED DOSE INHALERS

I authorize St. Philomena School to permit my child to carry and self-administer his/her inhaler according to the physician's instructions below. The inhaler must have the pharmacy's prescription label affixed to the outside.

I authorize the physician and school nurse to consult on this medication/condition.

_____ _____

(Student's Name) (Signature of Parent/Guardian) (Date)

_____ _____

(Physician) (Physician Phone Number)

Physician Order

I request that the following medication be carried and self-administered to my patient as directed:

Name of patient: _____

Name of medication: _____

Dose of medication: _____

Frequency of medication: _____

Reason/Indication: _____

Duration of medication: _____

I assume responsibility for medication used.

_____ _____

(Date) (Signature of Physician)