ST. PAUL LUTHERAN SCHOOL | LAKE MILLS, WISCONSIN

Asthma Inhaler Administration Authorization Form

Student Name____**Date of Birth**_____________________

Parent Signature__________________________________**Parent Phone #** _______________________

Diagnosis: ____

In order for the student to receive the asthma relieving medication for asthma:

- Asthma inhaler administration authorization form must be completed & signed by parent and medical provider. Form will be returned to the school office.
- Asthma inhaler medication must be properly labeled (medication/student names and directions for use.)
- The authorization of asthma relieving medication must be updated annually for use at school.

Students need skill, knowledge & authorization to use asthma relieving medication. Below are varied levels of administration. **Please check** all levels that you desire based on this child's skill and knowledge.

_____Student can self-administer asthma relieving medication. Student will seek the care of the school personnel if medication is unsuccessfully controlling his/her asthma.

_____ Student can self-administer asthma relieving medication with access to another inhaler in the school if needed. (Parents will supply school with a secondary inhaler.)

_____ Teacher needs to assist student in administrating the asthma relieving medication with the medication available as needed in the school.

Drug name:	Dosage:	Route:	Frequency:	Start date:	Stop date:	Side Effects:
1.						
2.						

School personnel may contact the medical provider of the medication for clarification regarding indication for use, medication, dosage, side effects, successful and treatment failures.

Medical Provider Signature:______________________________________**Date:**___________________

Medical Provider Name:____**Phone #**_________________

(please print)

Clinic Offices:____**Phone #**________________

(please print)

(*Parents*, please bring this form to school office with medication in original prescription bottle properly labeled.
***Office staff*, copy this form placing original in the student health file, giving duplicate/log & medication to teacher.**
***Teacher,* place meds in secure location, duplicate/log form in class notebook, administer/record as instructed.)**

ST. PAUL LUTHERAN SCHOOL | LAKE MILLS, WISCONSIN

Medical Provider's School Authorization Form
(For prescription medication)

Student Name____**Date of birth:** ______________

Parent Signature_________________________________**Parent Phone #**______________________

Student Diagnosis: ____

St. Paul Ev. Lutheran School is authorized to give the following medication(s) to above named student…

Daily Medication/Dosage	Route	Frequency	Start Date	Stop Date	Considerations/Side Effects
1.					
2.					

Medicine as needed (PRN) … Dosage	Route	Frequency	Start Date	Stop Date	Considerations/Side Effects

As a part of the Wisconsin Statute Chapter 118.29, schools are required to have permission from a medical provider to administrator medications at school. As part of the authorization form, school employees may contact the medical provider and parent with questions regarding the medication administration including clarification regarding dosage, side effects or indication of the medication(s) listed above.

Medical Provider Signature:______________________________________**Date:**__________________

Medical Provider Name:____**Phone #**________________
(please print)

Clinic Offices:____**Phone #**________________
(please print)

(*Parents*, please bring this form to school office with medication in original prescription bottle properly labeled. *Office staff*, copy this form placing original in the student health file, giving duplicate/log & medication to teacher. *Teacher,* place meds in secure location, duplicate/log form in class notebook, administer/record as instructed.)