

DIOCESE OF CHARLOTTE

ASTHMA TREATMENT AUTHORIZATION FORM

Student's Name _____ Birth Date _____

Grade _____ Homeroom/Teacher _____

Check One:

() I request that my child be assisted in taking the asthma medication listed below at school by authorized persons.

() I permit my child to self-medicate as authorized by me and the physician (see below). Further, I request that should my child develop difficulty breathing at school, authorized persons may initiate emergency procedures need, listed below.

PHYSICIAN'S AUTHORIZATION

Name of Asthma Medication _____

Form of Medication (circle one): Inhaler / Tablet / Capsule / Sprinkles / Liquid / Other

Dose _____ Time to be given _____

PRN for (describe indication) _____

How soon can it be repeated? (PRN Only) _____

* Is the student authorized to self-medicate? YES NO (See reverse side of form)

Significant Side Effects _____

Contraindications for Administration _____

If an emergency situation or reaction occurs, school officials are to:

a. Contact parent at home _____ work _____ mobile _____

b. Contact physician's office (print) _____ phone _____

c. For _____ reaction, take child to emergency at _____

Printed Physician's Name _____ Office Phone _____

Physician's Signature _____ Date _____ Fax _____

PARENT / GUARDIAN AUTHORIZATION

I hereby give my permission for my child, named above, to receive medication during school hours. I hereby release the Diocese of Charlotte, their agents, and their employees from any and all liability whatsoever that may result from my child taking this prescribed medication. I am responsible for providing the medication in a properly labeled pharmacy container with identifying information (child's name, medication, dosage, time to be given).

Parent's Name _____ Home Phone Number _____ Date _____

Printed Parent's Name _____ Work / Mobile Phone _____