Twin Valley School District

Authorization for Inhaler and Asthma Action Plan

(Form must be completed in it entirety)

Child's Full Name: _____ Grade _____ Date of Birth: _____

Drug Allergies: _____

All Current Medication: _____

ACTION PLAN for Asthma Emergency – (Completed by physician)

Triggers: _____

Symptoms: _____

Personal Best Peak Flow: _____

Physician's Request for Asthma Medication Use at School

Name of Asthma Medication: _____

Dose to be given at school: _____ Time to be given at school: _____

Route of Administration: _____ Any instructions? _____

Date to start medication: _____ Date to end Medication: _____

Reason for medication: _____

Side Effects: _____

Does student understand side effects? _____ Any emergency response? _____

_____ I believe this child is able and responsible to carry and self-administer his/her inhaler during school activities. He/she has permission to so do and has been instructed on how to self-administer.

_____ _____

Physician's Signature **Printed Name**

_____ _____

Date **Phone Number**

Parent Request for Medication Use at School

According to the PA. State Board of Nursing, no medication can be administered in school except by written request of a physician and with parent permission. According to TVSD medication guidelines, a physician authorization is required for administration of prescription and over-the-counter medications. My signature on this document constitutes a complete waiver of liability claim in any and all respects against the Twin Valley School District and its Board of Directors and all employees unless the District is negligent with regard to any claim for injury in connection with administration of the medication.

Additionally, **I agree to hand deliver** the medication to the nurse's office in the original pharmacy or physician labeled container. I also accept responsibility to provide a physician's note and my written instructions if the medication is to be changed or discontinued. I give my permission for the school and physician to communicate regarding this medication and medical condition.

_____ I believe my child is able and responsible to carry and self-administer his/her inhaler in school, during field trips, and extra-curricular activities (including athletics and music). I give my permission for him/her to do so. If my child uses his/her inhaler he/she will notify the nurse as soon as possible after using the medication.

_____ _____ _____

Date Printed Parent/Guardian Name Parent/Guardian Signature

___ (Student may carry Inhaler upon clearance by the nurse)

School Use Only

_____Clearance to carry and self- administer an inhaler has been given and initialed by the school nurse.