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