MOUNTAIN POINTE HIGH SCHOOL
ASTHMA MEDICATION PERMISSION SLIP
SCHOOL YEAR __________

PERMISSION FOR ASTHMA MEDICATION DURING SCHOOL HOURS

STUDENT NAME __________ **ID NUMBER __________**

This child is under treatment for asthma, and medication is required during the school day.

NAME OF MEDICATION	DOSE & FREQUENCY	TIME TO BE GIVEN	DURATION

It is recommended that the student both carry an inhaler and have a back-up inhaler available in the Health Office.

☐ **This student may carry an inhaler on their person during school hours.**

☐ **This student will have an inhaler in the Health Office.**

This student has been instructed in the self-administration of the above asthma medication, and circumstances under which to use the medication.

Print Name of Physician ______________________________

Physician's Signature ______________________________

Physician's Address ______________________________

Physician's Emergency Phone Number ______________________________

I give permission for my child to receive the above asthma medication as directed by the physician. The medication will be sent to school in a container appropriately labeled by the pharmacy. I will obtain a written doctor's order if the medication dosage is changed or the medication is discontinued. I will bring medication to the school nurse if it is to be left in the Health Office. If my child is carrying an inhaler on their person, I acknowledge that the student is responsible for having the medication available as needed and that the student has demonstrated competency in the proper way to use the medication. I understand that it is my responsibility to pick up any unused medication at the end of the school year, or it will be disposed of. I also understand that I will not receive a reminder notification or telephone call to pick it up.

Parent's Signature ______________________________

Date ______________________________

Phone Numbers
(home, work, cell) ______________________________