INHALER INSTRUCTIONS

The Diocese of St. Augustine requires that the attached forms be on file in the school office for children with inhalers that are used at school. Please note the following:

1. Both the Medication Authorization form and the Inhaler form should be completed and signed by parent and physician. (The Inhaler form covers inhalers that are kept in the clinic as well as those carried with the student.)

2. If you elect to have the inhaler carried by your child, the child must have the inhaler on his/her person at all times and may not leave the inhaler in a backpack or locker. If you do not think your child is capable or responsible enough to ensure that the inhaler is with him/her, please select the option to keep the inhaler in the clinic at the school.

3. We are unable to administer the medication in the event your child needs it, if these forms have not been properly completed, signed, and submitted to the office.

4. You are required to submit new forms every school year.

5. Please ensure that medication that is provided to the school is not close to or past its expiration date, as we will be unable to administer the medication if the expiration date has passed.

Medical Authorization

The following section is to be completed by the **PARENT/GUARDIAN** for the administration of medication. Medications must be in original containers.

Child's Name: _____ _____ _____
Last First Sex Date of Birth

_____ (____) _____
Physician's Name Address Telephone

I deliver the medicine(s) described below to ***Name of School*** *to be held for use by my child in accordance with the instructions given below. I consent and authorize the person designated by the School to dispense and to supervise my child's self-administering the medicine(s). We/I understand that the School assumes no responsibility for the instructions we/I have provided below, other than to allow my child to self-administer the medicine(s) and we/I assume all risk associated with the child's taking such medicine(s).*

We/I understand that under the provision of Florida Statute 232.46, school personnel cannot be held liable for reactions or side effects from the administration of the medication(s). We/I also grant permission for school personnel to contact the physician if there are questions or concerns about the medication(s).

_____ (____)_____ (____)_____
Date ***PARENT/GUARDIAN*** Signature Home Phone Emergency Phone

The following is to be completed by the **PHYSICIAN**:

Diagnosis for which medication is given: _____

Name of Medicine _____

Form _____

Dose _____

If medicine is to be given DAILY, at what time? _____

If medicine to be given "WHEN NEEDED," describe indications: _____

How soon can it be repeated? _____

Is child authorized to medicate herself/himself? _____

List significant side effects: _____

Length of time this treatment is recommended: _____

Other information: _____

_____ _____
Date Physician Signature

Diocese of St. Augustine
Parental Authorization for Student to Self-Medicate Via a Prescription Inhaler

Date: _____

Student's Name: _____ Birth Date: _____

School: _____

Teacher's Name: _____ Grade/ Homeroom: _____

As the parents/guardians of the student named above, we/I authorize him/her to take (self-administer) the following medication at school:

Name of Medication: _____ Amount/ dosage: _____
Time Student will take Medication: _____ Date Medication will Start: _____
To end: _____ Physician's Name: _____
Health Problem Requiring Medication: _____
Possible Reaction/ Side Effects: _____
_____

Where medication will be kept at school:

_____ 1) With student in an appropriate carrying case
_____ 2) In administrative office or clinic (locked)

It is understood that school personnel will not be responsible or liable of the administration of the medication listed above. It is further understood that proper instruction in the use of the inhaler has been given to the parent and the student by the authorizing physician. Permission is also granted for the school personnel to contact the physician if there are questions or concerns about the medication. We/I are aware the privilege of self-administration of medication can be withdrawn if abused by the student.

_____ _____
Parent/ Guardian Signature Date Work Phone

_____
Home Phone

_____ _____
Parent/ Guardian Signature Date Work Phone

_____
Home Phone

Note: Whenever possible, medication schedules should be arranged to all medication is given at home.
1.Only prescription medication will be administered at school. Over-the-counter and sample medications must be accompanied by orders from the physician.
2.Medication must be delivered to school in the container in which it was purchased (dispensed). The label must indicate the student's name, name of the medication, doctor's name, dosage (amount), time (frequency).
3. The inhaler must have the child's name on it. If the medication requires additional equipment for administration such as a spacer, the parent is responsible for supplying the articles properly labeled with the student's name.
4. A log will be kept by the student and school staff at an elementary site. Included in the log should be date, time, and frequency of inhaler use.

Diocese of St. Augustine
Physician's Orders for Self-Administration of Inhaler by Student at School

SPECIAL NOTE: The physician's orders must be accompanied by signed parental authorization form.

TO: The Physician

The information requested below is needed if a student is to use an inhaler in a Diocese of St. Augustine School. We appreciate your assistance in this matter.

Full Name of Student: _____ Birth Date: _____
Home Address: _____
Home Phone: _____ Parent/ Guardian's Work Phone: _____

Physician's Name: _____ Phone: _____
Health Problem Requiring Inhaler: _____
Name of Medication: _____
Amount to be Given: _____
When/ How Often: _____
What other emergency procedures should be instituted if inhaler proves ineffective:
_____
_____
_____
_____
_____

It is understood that school personnel will not be responsible or liable for the administration of the medication listed above. It is further understood that proper instruction in the use of the inhaler has been given to the parent and student by you/ your staff. The privilege of self-administration of medication can be withdrawn if abused by the student.

Physician's Signature:_____
Date:_____