



**MOST PRECIOUS BLOOD SCHOOL**  
1529 Barthold Street  
Fort Wayne, Indiana 46808  
260-424-4832  
[www.preciousblood.org](http://www.preciousblood.org)

## **Inhaler Self-Administration**

Student \_\_\_\_\_ Grade \_\_\_\_\_

### **To be completed by a physician/practitioner:**

My patient \_\_\_\_\_ has been instructed in the proper use of his/her inhaler.

The inhaler I have prescribed is \_\_\_\_\_. My patient is authorized to use the inhaler \_\_\_\_\_ times per day or as follows: \_\_\_\_\_.

The prescription for the inhaler expires \_\_\_\_\_. This student's well being is in jeopardy unless the inhaler is carried on his/her person; therefore, we request that he/she be permitted to carry the inhaler. He/she understands the purpose, appropriate method, and frequency of the use of this medication.

Physician/Practitioner: \_\_\_\_\_ (Stamp or Print)

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

### **To be completed by Parent/Guardian:**

I permit my child to carry the above listed inhaler as ordered by his/her physician/practitioner. I understand that my child, not the school, is responsible for the storage, possession, and use of the inhaler. I understand that sharing medication with other students will result in disciplinary action.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### **To be completed by the Student:**

I understand the purpose, appropriate method, and frequency of use of this inhaler. I understand that I, not the school, am responsible for the storage, possession, and use of the inhaler. I understand that haring medication with other students is potentially dangerous and will result in disciplinary action

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**This form must be completed in addition to the routine medication authorization form.**