PHYSICIANS REQUEST FOR STUDENT TO CARRY INHALER ON PERSON

Name of Student _____ Birth Date _____ ID Number _____

Address _____ Telephone Number _____ Zip Code _____

The above named student has _____
Name of Disease, condition or Syndrome

I am requesting that the above named student be allowed to carry their inhaler and Self-administer the following medication during school hours. I certify that the above named student has been instructed in the usage and self-administration of the following medication:

Name of Medication _____ Inhaler _____

Dosage / Frequency of Use _____

He/She understands the need for the medication, and the necessity to report to school personnel any unusual side effects. He/She is capable of using this medication independently.

Physician's Name _____ **Hospital Affiliation** _____
Please Print or Type

Address _____ **Telephone #** _____ **Fax #** _____

Physician's Singature _____ **Date** _____

*This request is valid for 1 year from date of signature. Any medication change or dose requires a new request form.