WARWICK SCHOOL DISTRICT
ASTHMA INHALER – SELF ADMINISTRATION AUTHORIZATION FORM

TO BE COMPLETED BY PARENT/GUARDIAN:

STUDENT'S NAME_____ BIRTHDATE_____

TEACHER/GRADE_____

By signing below:

1. I authorize the Warwick School District and its employees to allow my child to possess and use his/her asthma inhaler (a.) while in school, (b.) while at a school-sponsored activity, (c.) while under the supervision of school personnel and/or (d.) before or after school hours.
2. I agree that my child will demonstrate to the school nurse the proper use and technique for self administration of the asthma inhaler.
3. I agree that my child will notify the school nurse or qualified school personnel immediately following each use of the asthma inhaler, and sign his/her medication record.
4. I acknowledge that the school bears no responsibility for ensuring that the medication is taken or properly self administered. It is recommended for the protection of the child that a second inhaler be kept in the nurse's office in case the student does not have his/her inhaler.
5. I agree that the school nurse may contact my child's health care provider for the release and exchange of information concerning my child's diagnosis and treatment.
6. I understand that neither the district nor any of its employees shall be held liable for any injury resulting from self-medication, and I agree to indemnify and hold harmless the school district and its agents against any related claims.
7. I agree that if my child abuses or ignores this privilege, school personnel may confiscate the asthma inhaler and the district will remove my child's privilege to carry the medication.

_____ _____
Parent/Guardian Signature Date

TO BE COMPLETED BY THE STUDENT'S HEALTH CARE PROVIDER:

Medication _____ Dosage_____

Time and Frequency to be Administered _____

Diagnosis_____

Possible Side Effects_____

Expected Duration/ Discontinuation Date _____

Specific Directions/ Emergency Response _____

As the health care provider for this student, I verify that he/she has been taught proper use of his/her inhaler, has adequate knowledge of asthma and how to control it, and is thought to be responsible enough to carry his/her inhaler and use it properly without supervision.

_____
Physician's Printed Name Address Phone

_____
Physician's Signature Date Fax Number

NOTE: REQUESTS ARE EFFECTIVE FOR ONE SCHOOL YEAR ONLY AND MUST BE RENEWED ANNUALLY OR WHEN THERE IS ANY CHANGE IN PRESCRIPTION.

(Rev 6/12)

WARWICK SCHOOL DISTRICT

Warwick High School **Lititz Elementary School**

Warwick Middle School **Kissel Hill Elementary School**

John Beck Elementary School

John R. Bonfield Elementary School

Asthma Action and Emergency Care Plan

Student's Name: _____ Grade/Teacher: _____

DOB: _____ Gender: M ___ F___ School: _____

Parent/Guardian Name: _____

Telephone: (home)_____ (work) _____ (cell) _____

Parent/Guardian Name: _____

Telephone: (home) _____ (work) _____ (cell) _____

Emergency Contact Name (if parent/guardian not available): _____

Telephone # for Emergency Contact: (home) _____ (work) _____ (cell) _____

Name of Healthcare Provider: _____ Telephone #: _____

Asthma Severity: ( ) Mild ( ) Moderate ( ) Severe

Asthma Triggers: Colds/ Respiratory Infections Exercise Animals Dust Smoke Strong odors/perfumes

Pollens/Mold Weather Food _____ Other _____

Asthma Symptoms: Wheeze Tight Chest Cough Difficulty Breathing Other _____

Emergency Actions/Care Needed (Explain) Note: A signed order from the child's physician and written parent permission is required each school year for medications to be administered. Parents who request that the student self-carry his or her asthma inhaler must complete the Asthma Inhaler Self Administration Authorization Form each school year.

Note: **You are encouraged to alert all other school and after-school personnel (transportation, cafeteria, coaches, etc.) who may have contact with your child, so that they are aware of your child's diagnosis and treatment that may be needed.**

Parent/Guardian Signature: _____ Date: _____

Certified School Nurse Signature: _____ Date: _____