|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| St. Patrick Interparish Catholic School  550 NE 16th Avenue Gainesville, FL 32601  352.376.9878 FAX: 352.371.6177 | | | | | | **Physician’s Authorization for Self-Administration of Inhaler by Student at School** | |
| Student Name | | | Grade: | | | | |
| Date of Birth | | |  | | | | |
| Parent(s)/Guardian(s) | | |  | | | | |
| Address | | |  | | | | |
|  | | | | |
| Dear Doctor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  It is understood that school personnel will not be responsible or liable for the administration of the medication listed below. 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 The privilege of self-administration of medication can be withdrawn if abused by the student. | | | | | | | |
| **To Be Completed by Physician** | | | | | | | |
| **Medication** | 1 | | | 2 | | | 3 |
|  | | |  | | |  |
| **Indication** | 1 | | | 2 | | | 3 |
|  | | |  | | |  |
| **Dose** | 1 | | | 2 | | | 3 |
| **Frequency** | 1 | | | 2 | | | 3 |
| **Emergency Procedures** | *In the event the above interventions are not effective, please list additional measures to be taken.* | | | | | | |
|  | | | | | | |
|  | | | | | | |
|  | | | | | | |
|  | | | | | | |
|  | | | | | | |
| **RECREATIONAL ACTIVITIES:** |  | The child may participate in recreational activities. | | | | | |
|  | Activity restrictions: | | | | | |
|  | Other restrictions: | | | | | |
| **Physician** | | | | | **Parent(s)/Guardian(s)** | | | |
| Print Name: | | | | | Print Name: | | | |
| Address: | | | | | Relationship: | | | |
| Phone: | | | | |
| Signature: | | | | | Signature: | | | |
| Emergency Contact #: | | | | | Emergency Contact #: | | | |
| Date: | | | | | Date: | | | |