



**Inhaler Medication
Self –Administration Form**

Parent/guardian request for self-administration of inhaler during school hours –

Student Name & Grade _____

Medication to be Given _____

Medication Dosage and Frequency _____

Reason for Medication _____

This student has received asthma education in my office regarding the safe self-administration of the above medication.

(Physician Signature) (Telephone Number) (Date)

(Parent/Guardian Signature) (Telephone Number) (Date)

*We request that students report to the nurse after the inhaler is used to determine the effectiveness of the medication. *

M5
(revised 6/03)



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