

**AUTHORIZATION TO CARRY AND
SELF-ADMINISTER ASTHMA MEDICATION**

(This shall serve as an IHCP unless more information is needed in which case an attachment will be created)

Massachusetts State Law and Regulations require a physician's written order and a parent's/guardian's consent for a student to administer medication to him/herself. Medication must be in the original pharmacy prepared container and labeled with the name of the child, name of drug, strength, dosage, frequency, physician's name and date of original prescription. For inhalers this information is provided on the box and not the inhaler itself. Please label your child's inhaler with his/her name in permanent marker.

.....

PHYSICIAN'S ORDER

Name of child _____ Date _____
Address _____ Date of Birth _____
Diagnosis for which drug is prescribed _____
Drug Name _____ Drug Dosage _____
Method of Administration _____ Time(s) Given _____
This order is valid for one school year (and no longer than) unless otherwise stated below:

Possible side effects to be observed: _____
If side effects are noted during school hours, what is the management plan for the side effects:

Student has received proper instruction of medication administration while at the physician's office:
YES NO

In my opinion, this child can carry and self-administer the above prescribed medication appropriately and safely: YES NO

Physician's Name (PRINTED) _____ Phone _____

Physician's Signature _____ Date _____

.....

PARENT CONSENT FOR SELF-ADMINISTRATION

I agree that my child _____ is solely responsible to carry and self-administer the above named medication available for use at all times during the school hours (including, but not limited to, all related school activities, and transportation to and from school.)

I WILL or WILL NOT provide a back-up inhaler to remain in the nurse's office for emergency purposes. I recognize that by not providing the school nurse with an extra inhaler that my child will have no access to one if he/she forgets or loses his/her inhaler.
(circle one)

Parent/Guardian's Name (PRINTED) _____

Parent/Guardian's Signature _____ Date _____

Inhaler Received: YES NO RN Signature _____ Date _____