WASHINGTON EPISCOPAL SCHOOL

PHYSICIAN'S AUTHORIZATION FOR MEDICATION BY <u>INHALER/MECHANICAL DEVICE</u>

ONE MEDICATION PER FORM

FOR COMPLETION BY PARENT(S)/GUARDIANS(S)

Name of Student ____Grade________________________

- I understand that I must supply the school with the equipment/supplies needed to administer the medication.
- I understand that all medications must be labeled with the name of the medication, name of the student, name of the physician, date, and directions for administration. Prescription medication must be labeled by a registered pharmacist.
- I hereby authorize the medication described below to be administered as directed by my child's physician.
- I understand that the physician will be called if a question arises about my child's medication.
- 911 will be called immediately if there is a problem.

____ _________________________________

Signature of Parent *or* Legal Guardian Date

FOR COMPLETION BY PHYSICIAN

1. Name of medication ____ Strength ______________________
2. Reason for medication ____
3. Type of device ____
4. Specific directions for use ____

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- Is the student capable of **self-administering** the medication by device? _____ yes _____ no
- Should the student **carry** medication and device with him/her? _____ yes _____ no

5. Dosage of medication ____
   (Number of puffs)
6. Time of day medication is to be given ____
7. Side effects ____
8. Date medication began _________________________ Date medication discontinued ________________________

This medication authorization is valid only for one year.

____ ______________________________________

Physician's Signature (No stamps) *and* **Date** *Parent* or Legal Guardian Signature *and* **Date**

____ ____

Physician's Name Printed *Parent* Name Printed

____ ____

Physician's Telephone Number *Parent* Telephone Number