



**SAINT MARTIN**  
DE PORRES *High School*

**PHYSICIAN/AUTHORIZED PRESCRIBER  
REQUEST FOR MEDICATION WITH  
ASTHMA INHALER AT SCHOOL**

**Student Name:** \_\_\_\_\_ **Birthdate:** \_\_\_\_\_ **Grade:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Telephone:** \_\_\_\_\_

**Name of Inhaler Medication** \_\_\_\_\_

Dose	Frequency (Daily, PRN, etc.)	Time(s)

Is student responsible and capable of self-administering this medication?

\_\_\_ Yes \_\_\_ No

May student carry this medication in school? \_\_\_ Yes \_\_\_ No

**Start date:** \_\_\_\_\_ **End date:**  End of school year or  \_\_\_\_\_

Adverse reactions that should be reported to the physician:

\_\_\_\_\_

Procedure to follow in the event that medication does not produce the expected relief from student's asthma attack:

\_\_\_\_\_  
\_\_\_\_\_

Medications/doses at home: \_\_\_\_\_  
(List all that apply)

\_\_\_\_\_  
Physician/Authorized Prescriber Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Telephone

**PARENTS REQUEST AND RELEASE FOR ADMINISTRATION OF  
MEDICATION AT SCHOOL**

I give permission for my child, \_\_\_\_\_, to receive the above medication at school according to the prescriber's order and school policy. It is understood that St. Martin de Porres High School and all of its personnel are absolved from any liability which might be associated with the administration of such medication. I understand that the medication must be brought to school in the container in which the pharmacist dispensed it. I give permission to the School Nurse to communicate with the prescriber regarding my child's treatment plan.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Telephone (work /cell/ emergency)

Reviewed by Nurse (name): \_\_\_\_\_ date: \_\_\_\_\_