TORAH SCHOOL OF GREATER WASHINGTON

ASTHMA INHALERS USAGE FORM

Parents: So that we may provide the best care for your child, please complete this form and return it to the school medication assistant. If any changes occur during the year, please notify that person.

Choose the option you want for your child.

❑ Option #1

The student comes to the office where the inhaler is kept, and uses it under supervision. The advantage is that the medication will be used correctly, in the proper amount, and records will be kept.

A number of students keep inhalers in the office and come before PE, recess or as needed.

All medications brought to school must be in their original container. Prescription medications require a parental/physician form to be filled out and sent with the medication. Over the counter asthma medications require written parental permission to be sent with the medication.

❑ Option #2

QUALIFIED students will be allowed to carry their inhalers. The advantage is that it is immediately accessible. A spare inhaler provided by the parent may be kept for them in the office should they forget theirs or run out.

CONTRACT BETWEEN STUDENT, PARENTS, MEDICATION ASSISTANT AND DOCTOR FOR PERMISSION TO CARRY INHALERS

1. Student has demonstrated to the medication assistant correct use of the inhaler.
2. Student agrees to never share the inhaler with another person.
3. Student agrees that after two puffs, if there is not marked improvement, he/she will see the medication assistant immediately.

Student Signature _____ Date _____

I give permission for my child _____ to carry the inhaler(s) described below. I understand that he/she must follow the rules listed above. I will notify the school of changes in medication or my child's condition.

_____	_____	_____
Name of Medication	Dose	Frequency of Use
_____	_____	_____
Name of Medication	Dose	Frequency of Use

Physician Signature _____ Date _____
Print Physician Name_____ Phone _____
Parent Signature _____ Date _____
School Medication Assistant Signature _____ Date _____