TORAH SCHOOL OF GREATER WASHINGTON

ASTHMA INHALERS USAGE FORM 2018-2019

*Must be accompanied by the Medication Administration Authorization Form

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

STUDENT NAME: _____ DATE OF BIRTH: _____

My Child's asthma is triggered by: _____.

Has emergency treatment and or hospitalization been needed in the past? If yes to either, please specify:

_____

My Child takes *maintenance* asthma medication: yes / no (circle one).

_____	_____	_____
Name of Medication	Dose	Frequency of Use

Choose the option you want for your child in school.

❑ Option #1

The student comes to the Health Room 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 Health Room and come before PE, recess, or as needed.

- All medications brought to school must be in their original container.
- An adult must bring the medication to school and pick it up at the end of the year.
- The School Nurse will call the prescriber, as allowed by HIPPA, if a question arises about the child and /or the child's medication.

❑ Option #2

QUALIFIED students will be allowed to carry their inhalers. The advantage is that it is immediately accessible. We recommend that a second inhaler be kept in the Health Room should they forget theirs or run out.

CONTRACT BETWEEN STUDENT, PARENTS, SCHOOL NURSE, AND PHYSICIAN TO SELF-CARRY INHALER

1. Student has demonstrated to the School Nurse 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 notify a teacher and see the School Nurse 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

Physician Signature _____ Date _____
Print Physician Name_____ Phone _____
Parent Signature _____ Date _____
School Nurse Name and Signature _____ Date _____