THE MASTER'S ACADEMY
AUTHORIZATION FOR ASTHMA MEDICATION ADMINISTRATION AT SCHOOL

School Year: 20___ to 20___

Date: _____ Student: _____D.O.B._____ Grade: ___
Asthma Triggers:
_____

To Be Completed by Physician:
Current Asthma Condition: [ ] Intermittent [ ] Moderate Persistent
[ ] Mild Persistent [ ] Severe Persistent
[ ] Exercise Induced
The above student has been diagnosed with asthma and, on occasion, will require the following asthma medication to be administered at school:

Medication to be administered via inhaler: Drug: _____
Dose: _____
Frequency: _____

Medication to be administered via nebulizer: Drug: _____
Dose: _____
Frequency: _____

Other Medication: Drug: _____
Dose: _____
Frequency: _____
The student has been instructed and demonstrates proper technique to administer his/her asthma medication. He/she may carry and self-administer his/her inhaler during the school day.
Yes _____ No _____ Location of Inhaler at School: _____

- *Parents, please consider storing additional rescue inhaler in the school clinic.*

Comments: _____
I understand that The Master's Academy does not have access to peak flow meters at this time.
This information will remain confidential and only shared with school personnel, as needed, for the student's health and educational needs. This authorization includes permission for communication between the school nurse and a student's health provider regarding the medication if necessary.

Signed: _____Print: _____Date:_____
PHYSICIAN signature required

Signed: _____Print:_____Date:_____
PARENT/GUARDIAN signature required

FAX Number: 407-971-1373