BISHOP HOFFMAN CATHOLIC SCHOOL

AUTHORIZATION FOR THE POSSESSION AND USE OF EMERGENCY ASTHMA MEDICATION

Student Name_____ Date of Birth_____ School Year_____
Home Address_____ School_____ HR/Grade _____

Medication_____ Dosage_____ Route_____

Administration Time(s) _____ Beginning Date _____- _____ /end of school year

___After giving medication monitor student 15-20 minutes, if improved, may resume normal activities

___If not improved, repeat medication in _____minutes x_____ Continue to monitor. Call parents. Call school nurse.

___If not improved after above actions- call emergency services (9-1-1)

___Special Instructions_____

__Possible adverse reactions (which should be reported to the parent and physician): additional breathing problems, if the medication doesn't work, nervousness, fast heart-rate, shaking/tremor, headache, nausea, vomiting, cough, irritation in the throat, muscle, bone, or back pain, _____

__Possible adverse reactions for unintended user: nervousness, breathing problems, fast heart-rate, shaking/tremor, headache, nausea, vomiting, cough, irritation in the throat, muscle, bone, or back pain, _____

Physician Authorization:

[ ] The medication will be stored in the school health office and the student will receive the medication above from designated school personnel.

----------OR----------

[ ] The student will keep emergency medication in his/her possession and self-administer medication as prescribed and I affirm that the student listed above:

- **Has demonstrated correct use/administration of this medication**
- **Recognizes proper and prescribed timing for medication**
- **Does not share medication with others**
- **Keeps medication in agreed location**

We strongly encourage that a back-up inhaler is kept in the school health office in the event of an emergency.

Healthcare Provider Signature_____ Date_____

Provider Name _____ Phone_____ Fax _____

Parental authorization MUST be completed on back (page 2):

BISHOP HOFFMAN CATHOLIC SCHOOL

AUTHORIZATION FOR THE POSSESSION
AND USE OF EMERGENCY ASTHMA INHALER

Parent/ Guardian Authorization:

- As a parent or legal guardian of the above named child, my signature below authorizes school personnel to administer the medication as instructed by the physician. I understand that a trained staff member administering the medication might not be a health professional.
- I authorize the student named above to have access to and use the medication as ordered above.
- I understand that a new authorization form is required each school year and when there is a change in the medication. I will notify the school immediately with any medication changes.
- I understand the medication must be in the original container and properly labeled with student's name, date, prescriber's name, name of medication, dosage, strength, route and time of administration and drug expiration date.
- I assume responsibility for the safe delivery of the medication to and from school. If the medication expires during the school year, I understand it is my responsibility to bring in new medication as soon as possible.
- I authorize the Health Services staff to communicate with the student's healthcare provider as needed regarding this medication.
- I release and agree to hold the BHCS Board of Education, its officials, and its employees harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.

Parent/Guardian signature_____ Date_____

Parent guardian name_____ _____

Phone number(s): _____ _____

Copy to School Nurse
Copy to Principal

(updated 3/6/17)