



Howard-Suamico School District
Authorization to Administer
INHALED MEDICATIONS
(Use a separate authorization form for each medication)

Student: _____ DOB: _____
School: _____ Grade: _____

FOR COMPLETION BY PHYSICIAN

Name of Medication: _____
Delivery of Medication: ☐ Inhaler ☐ Spacer ☐ Nebulizer
Dosage: _____
Administration: ☐ Daily/Scheduled. Time: _____
☐ As needed: Indication for use: _____
If needed, how soon can administration of inhaled medication be repeated? _____
Inhaled medication cannot be repeated more then: _____
Side effects/comments: _____

Student is knowledgeable about his or her inhaled medication? ☐ yes ☐ no
Student demonstrates proper technique in administering inhaled medication? ☐ yes ☐ no
Student needs assistance/supervision in administer inhaled medication? ☐ yes ☐ no
I authorize student to carry and administer inhaled medication by him/herself? ☐ yes ☐ no

Physician's Name: _____
Telephone Number: _____
Fax Number: _____

Physician Signature: _____ Date: _____

Fax completed signed form to 920-662-7900 – Pupil Services

FOR COMPLETION BY PARENT/GUARDIAN

I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.

I authorize student to carry and administer inhaled medication by him/herself? ☐ yes ☐ no

Parent/Guardian Phone #1 _____
Parent/Guardian Phone #2 _____
Parent/Guardian Name (print) _____

Parent/Guardian Signature: _____ Date: _____

Parent: Return completed signed form to school office.