



### Inhaled Medication Authorization Form

Legal Last Name: \_\_\_\_\_ Legal First Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Studio Level: \_\_\_\_\_

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#### **To Be Completed by Licensed Healthcare Provider with NO Abbreviations**

Diagnosis: \_\_\_\_\_

List of Triggers: \_\_\_\_\_

Signs or Symptoms: \_\_\_\_\_

Name of Medication: \_\_\_\_\_

Start Date of Medication: \_\_\_\_\_ End Date of Medication: \_\_\_\_\_

Method of Delivery: \_\_\_\_\_ Dosage: \_\_\_\_\_

Administration:

Daily Time: \_\_\_\_\_

As Needed: (Explain signs or symptoms that would indicate medication needs to be given.)

Interval for repeating dosage: \_\_\_\_\_

Medication cannot be repeated more than: \_\_\_\_\_

Side effects or additional comments: \_\_\_\_\_



- Student has received adequate information on how and when to use their inhaler and can administer the inhaler to themself.
- The student requires assistance with administering medication.
- A New Leaf Prep Academy staff member must administer the inhaler to the student.
- The student's inhaler is to be stored within their classroom and carried with them during events for quick access. (A back up must be stored in the office.)
- The inhaler will be stored in the office during the school day.

Name of Healthcare Provider: \_\_\_\_\_ Phone: \_\_\_\_\_

Signature of Provider: \_\_\_\_\_ Date: \_\_\_\_\_

Name of Parent/Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Student (Required if student carries inhaler) \_\_\_\_\_