WYNFORD LOCAL SCHOOLS

Physician's Request for the Self-administration of Asthmatic Inhaler

____________________ is under my care and is authorized to
student's name
carry the following medication(s) during school hours:

Name of drug, dosage:______________________________
Times of administration:______________________________

Specific Instructions:______________________________

Possible side effects:______________________________
Possible reaction experienced by a person not authorized to use this medication:______________________________

Date:______________ Physician's phone no.________________

Physician's signature______________________________

Parent's request for inhaler self-administration

I hereby request and give my permission for my child to carry the above medication at school. I have instructed my child on proper administration. I have also instructed my child as to the dangers to another child of using this medication, and have discussed precautions to prevent this from occurring.

Date:___________ Parent's signature______________________