INHALER AUTHORIZATION FORM

PART I TO BE COMPLETED BY PARENT/GUARDIAN

I hereby request LCA personnel to administer an inhaler as directed by this authorization. I agree to release, indemnify, and hold harmless LCA personnel, or agents from lawsuits, claim expense, demand or action, etc. against them for helping this student use an inhaler, provided LCA personnel comply with the Licensed Healthcare Provider (LHCP) or parent/guardian orders set forth in accordance with the provision of Part II below.

Inhaler ☐ Renewal ☐ New (If new, the first full dose must be given at home to assure that the student does not have a negative reaction.)

First dose given: Date: _____ Time: _____

Student Name: D.O.B.

Allergies: School: Legacy Christian Academy School Year: 2014-2015

_____ _____ _____

Parent's/Guardian's Signature **Daytime Telephone** **Date**

PART II TO BE COMPLETED BY LICENSED HEALTH CARE PROVIDER (Lay Language, NO Abbreviations)

DIAGNOSIS:	LIST TRIGGERS:
SIGNS / SYMPTOMS:	MEDICATION & ROUTE:
DOSAGE TO BE GIVEN AT SCHOOL:	INTERVAL FOR REPEATING DOSAGE:
TIME TO BE GIVEN:	COMMON SIDE EFFECTS:
EFFECTIVE DATE: Start: End:	If student is taking more than one medication at LCA, list sequence in which they should be taken.

Check ✓ the appropriate boxes:

☐ I believe that this student has received information on how and when to use an inhaler and that he/she demonstrates its proper use.

☐ The student is to carry an inhaler during school and during sanctioned events with LCA's approval.
(An additional inhaler, to be used as backup, will be kept in the school office.)

☐ It is not necessary for the student to carry his/her inhaler during school, the inhaler will be kept in the school office.

***Asthma Action Plan is attached.**

_____ _____ _____ _____

Licensed Health Care Provider's Name **Licensed Health Care Provider's Signature** **Date** **Phone**

_____ _____ _____ _____

Parent's/Guardian's Name **Parent's /Guardian's Signature** **Date** **Phone**

_____ _____

Student's Signature (Required if student carries Inhaler) **Date**