DIOCESE OF CHARLOTTE

ASTHMA TREATMENT AUTHORIZATION FORM

Student's Name		Birth Date	
Grade	_Homeroom/Teacher		
Check One:			
() I request that my child be assisted	in taking the asthma medication list	ed below at school by authorized persons.	
need, listed below.	e as authorized by me and the physici y breathing at school, authorized pers PHYSICIAN'S AUTHORIZAT	sons may initiate emergency procedures	
Name of Asthma Medication			
Form of Medication (circle one):	Inhaler / Tablet / Capsule / Sprin	nkles / Liquid / Other	
Dose	Time to be given		
PRN for (describe indication)			
How soon can it be repeated? (PR)	N Only)		
* Is the student authorized to se	lf-medicate? YES NO	(See reverse side of form)	
Significant Side Effects			
Contraindications for Administration	on	**************************************	
If an emergency situation or reaction	on occurs, school officials are to:		
a. Contact parent at home	work	mobile	
b. Contact physician's office (prin	.t)	phone	
c. For	reaction, take child to e	emergency at	
Printed Physician's Name		Office Phone	
Physician's Signature	Date	Fax	
I hereby give my permission for my ch	and their employees from any and all ation. I am responsible for providing	ion during school hours. I hereby release liability whatsoever that may result from the medication in a properly labeled	
Parent's Name	Home Phone Number	Date	
Printed Parent's Name	Worl	Work / Mobile Phone	