



Banner Christian School

P.O. Box 74010
North Chesterfield, Virginia 23236
Phone: 804-276-5200
Fax: 804-276-7620
www.bannerchristian.org

INHALER AUTHORIZATION

FOR USE WITH ASTHMA ACTION PLAN

PART I – TO BE COMPLETED BY PARENT OR GUARDIAN

STUDENT NAME (last, first, middle) _____ **Date of birth** _____

Grade _____ **School Year** _____

Allergies: _____

I hereby request a designated school MAT personnel to administer an inhaler as directed by this authorization. I agree to release, indemnify, and hold harmless the designated school MAT personnel, or agents from law suits, claim expenses, demand or action, etc., against them for helping this student us an inhaler, provided the designated school MAT personnel comply with the Licensed Healthcare Provider or parent/guardian orders set forth in accordance with the provision of part II below. I have read the procedures outlined in the remainder of this form and assume responsibility as required.

Inhaler: ___New ___Renewal If new, the first full dose MUST be given at home to assure that the student does not have a negative reaction.

First does was given: Date _____ Time _____

Banner Christian School's MAT personnel will not administer an inhaler or treatment, unless this form is filled out in completion and signed by a Healthcare Provider and the parent/guardian.

Parent/guardian

Daytime Telephone

Date

INHALER AUTHORIZATION continued

PART II – TO BE COMPLETED BY LICENSED HEALTHCARE PROVIDER (lay language, NO abbreviations)

Diagnosis: _____ Triggers: _____

Signs/Symptoms: _____

Medication and Route: _____

Dosage to be given at school: _____

Time to be given: _____

Interval for repeating dosage: _____

Side effects: _____

Action to be taken if side effects occur: _____

Effective Date: _____ If the student is taking more than one medication at school, list sequence the inhalers are to be taken.

Start Date: _____ End Date: _____ Date Parent to Pick-up from School: _____

Check the appropriate statement:

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 school sanctioned events with MAT personnel approval. An additional inhaler, to be used as a backup, WILL BE kept in the clinic or other approved school location.

It is not necessary for the student to carry his/her inhaler during school, the inhaler will be kept in the clinic or other approved school location.

Asthma Action Plan is attached.

Licensed Healthcare Provider (PRINT)

Licensed Healthcare Provider (Signature)

Phone Number

Date

Parent or Guardian (PRINT)

Parent or Guardian (Signature)

Phone Number

Date

Student Signature (Required if student carries inhaler)

PART III – TO BE COMPLETED BY SCHOOL MAT PERSONNEL

Check the appropriate statement:

___ Parts I & II above are completed including signatures. (It is acceptable if all items in Part II are written on the LHCP stationary or a prescription pad.)

___ Inhaler is appropriately labeled and in original packaging.

___ Date by which any unused inhaler is to be collected by the parent. (within one week after expiration of the physician order or last day of school)

I have reviewed the proper use of the inhaler with the student and ___ agree ___ disagree that the student should self carry in school.

MAT Personnel (PRINT)

MAT Personnel (Signature)

Date