3192 Turnpike St., Susquehanna, PA 18847 Phone (570) 853-4921 www.scschools.org

**Elementary School**
**Health Office**
Ext. 1343 & 1345
Fax: (570) 853-3092

**High School**
**Health Office**
Ext. 2347
Fax: (570) 853-3918

# PHYSICIAN/PARENT REQUEST FOR POSSESSION & SELF-ADMINISTRATION OF ASTHMA INHALER BY STUDENT

Special health care procedures and medications may be administered at school by school personnel when such treatment is necessary for school attendance and cannot be otherwise accomplished. This completed form, along with the medication and/or special equipment items are to be brought to the school by a parent in the original container appropriately labeled by the pharmacy (hint: parents may request that the pharmacist dispense two bottles of medication, one for home and one for school). Students who need to possess & self-administer asthma inhaler while in school must follow school policy (attached).

## HEALTH CARE PROVIDER SECTION (ITEMS 1-10)

1. Name of student _____ Grade _____
2. Name of medication/procedure _____
3. Diagnosis/condition for which prescribed medication/treatment is required
   _____
4. Dosage and route of administration/instruction (include time schedule)
   _____
5. Precautions/possible side effects _____
6. Curtailment of school activities (sports/gym/recess, etc) _____
7. Other medications (prescribed) that student takes outside of school hours
   _____
8. Is student capable of self administration? YES _____ NO _____
   May student carry asthma inhaler with him/her? YES _____ NO_____
9. Date of request _____ Date of termination _____
10. Identification of PA Licensed Health Care Provider

_____/_____
*Health Care Provider's Name (PRINTED)* *Health Care Provider's Signature*

_____/_____
*Health Care Provider's Address* *Health Care Provider's Telephone #*

## PARENT SECTION

I the undersigned parent/guardian of _____, in the case of self-administered asthma inhalers I:
*Student Name*

(a)relieve the SCDA of any responsibility for consequences or benefits of the medication (b) will not hold the SCSD responsible for ensuring that the medication is taken (c) I agree my child shall be subject to the consequences of the district Drug & Alcohol Policy for inappropriate use of the inhaler.

_____/_____
*Parent/Guardian Signature* *Date* *Telephone #*