Neshaminy School District
2001 Old Lincoln Highway • Langhorne, Pennsylvania 19047-3295

ASTHMA INHALER PHYSICIAN'S ORDER

Student name ___________________________________ Age ______ Date of Order ________________

Diagnosis ____
Name of medication ___________________________________Dosage ___________________________
Route /Time and/or frequency (be specific) ____

_________ The above student is qualified and able to carry and to self-administer an asthma inhaler.
_________ The above student should keep the asthma inhaler in the school health office and should be supervised during its use.
_________ In the event of a CLASS TRIP, the student may carry and self-administer the asthma inhaler.

Printed Name of physician _____________________________ Signature ___________________________

Address and phone number ____
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Parent permission/please check one line and sign below:

_____ I request that the Neshaminy School District comply with the request of my physician and allow my student to carry and self-administer an asthma inhaler. I relieve the Neshaminy SD and its personnel from all responsibility for my student's use or misuse of this medication including missed doses. I understand that my student may not share this medication with any other person and that he/she will notify the school nurse anytime the use of the inhaler is required. I authorize the school nurse to communicate with my child's health care provider, and my health care provider to reply as needed regarding this medication and my child's response.

_____ I request that my student keep their asthma inhaler in the school health office and I authorize the Neshaminy SD personnel to supervise my student in the use of the asthma inhaler in accordance with the policies of the Neshaminy SD. I authorize the school nurse to communicate with my child's health care provider, and my health care provider to reply as needed regarding this medication and my child's response.

Any medication administered by school personnel must be delivered to the school nurse, the school principal or his/her designee and is required to be in a container appropriately labeled by the pharmacy or a physician.

Parent Signature ________________________________

05/2014