

Genesee Christian School
Permission Form for Inhaled Asthma Medication ONLY

Student: _____ Date form received by the school: _____

Date of Birth: _____ Grade: _____

To be completed by the physician or authorized prescriber

Name of Medication: _____

Reason for Medication: (OPTIONAL) _____

Form of medication/treatment:

Tablet/capsule Liquid Inhaler Injections Nebulizer Other _____

Instructions (schedule and dosage to be given at school): _____

Start Date: _____

Stop Date: _____

For episodic/emergency events only

Restrictions and/or important side effects: None anticipated

Yes. Please describe: _____

Special Storage Requirements: None Refrigerate

Other: _____

This student is both capable and responsible for self-administering this medication:

No Yes-Supervised Yes-Unsupervised

This student may carry this medication: No Yes

Please indicate if you have provided additional information:

On the back side of this form As an attachment

Date: _____ Signature: _____

Physician's Name: _____

Address: _____

Phone Number: _____

To be completed by parent/guardian

I request that (name of child) _____ receive the above medication at school according to standard school policy. I understand that all over-the-counter and prescription medication is to be turned in to the office and kept there at all times with the exception of asthma inhalers providing a note from the physician.

Date: _____ Signature _____ Relationship: _____