



PHYSICIANS REQUEST FOR STUDENT TO CARRY INHALER ON PERSON

_____ Name of Student	_____ Birth Date	_____ ID Number
_____ Address	_____ Telephone Number	_____ Zip Code

The above named student has _____
Name of Disease, condition or Syndrome

I am requesting that the above named student be allowed to carry their inhaler and Self-administer the following medication during school hours. I certify that the above named student has been instructed in the usage and self-administration of the following medication:

_____ Name of Medication	_____ Inhaler
_____ Dosage / Frequency of Use	

He/She understands the need for the medication, and the necessity to report to school personnel any unusual side effects. He/She is capable of using this medication independently.

Physician's Name _____ Hospital Affiliation _____
Please Print or Type

Address _____ Telephone # _____ Fax # _____

Physician's Signature _____ Date _____

*This request is valid for 1 year from date of signature. Any medication change or dose requires a new request form.