ARCHDIOCESE OF LOS ANGELES
AUTHORIZATION AND PERMISSION
FOR INHALERS TO BE CARRIED BY STUDENTS

Part A, B and C to be completed by a Licensed Physician
Part D by Parent/Guardian – *please print*

A. ______________________________________ ________ ____________

Last Name of Student First Name Sex Birth Date

______________________________________ ______________________________

Diagnosis Inhaler Prescribed

__________________________ __________________ __________________

Dosage Prescribed Time Schedule at School Date of Prescription

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Length of time this inhaler will be necessary

B. Physician's Recommendations. (check where applicable)

_______Inhaler may have adverse effects (explain) ______________________________

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_______Special instructions and/or comments ______________________________

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C. Physician's Authorization. The student for whom this inhaler is prescribed is under my care.

________________________________ ____________________________

Print Name of Licensed Physician Signature of Licensed Physician

________________________________ __________________ ___________

Address Telephone Date

TO THE PARENT/GUARDIAN: THE STUDENT MAY CARRY THE INHALER AND USE IT AS PRESCRIBED, AFTER THIS FORM HAS BEEN FILED WITH THE SCHOOL HEALTH OFFICE.

PLEASE SIGN THE FOLLOWING STATEMENT:

D. Permission for Inhaler to be Self-Administered by Student During School Hours

I request that my child, be permitted to carry and self-administer the above-prescribed inhaler at school. I will comply with the policies and procedures determined by the school.

________________ ______________________ ______________________

Date Day Telephone Emergency Telephone