PLEASE HAVE YOUR CHILD'S DOCTOR COMPLETE THIS SECTION IF YOUR STUDENT IS GOING TO CARRY AND SELF-ADMINISTER THE INHALER

For Physician Use Only:

- **According to TN state law TCA 49-5-415 Students may carry and self administer a prescribed asthma reliever inhaler under the following circumstances: the physician must provide the name, purpose, dose of medication, and the time(s) or special circumstances for use. The physician must further document that the student has been trained in the proper use of the inhaler.**
- **Physician signature indicates agreement with the plan and an order in good standing for the current school year.**

Name of Student: ______________________ DOB: __________________ may carry and self administer the following metered dose asthma reliever medication by inhaler:

NAME OF MEDICATION:____

PURPOSE OF MEDICATION:____

TIME(S) OR CIRCUMSTANCES WHEN INHALER MAY BE USED:

____

THIS STUDENT HAS BEEN TRAINED BY A MEDICAL PROFESSIONAL TO INDEPENDENTLY USE THE METERED DOSE INHALER: ________ YES ______ NO

THIS MEDICATION MAY BE REPEATED AS DIRECTED IF SYMPTOMS PERSIST 15 MINUTES AFTER INITIAL USE.

_______ YES _______ NO Number of Puffs allowed: ______________________

Physician Signature: _____________________________________ Date: ___________________________

**Treatments, academic modifications or activity restrictions will require separate written orders from the student's physician.

I acknowledge that the school shall incur no liability and I indemnify and hold harmless the school and its employees against any claims relating to the possession or self-administration of the inhaler and my signature also indicates permission to notify staff of my student's individual health plan. I also give permission for the nursing department to contact my child's health care provider to obtain information or clarification regarding his/her medical condition. This consent form is binding for the entire school year unless I provide the school nurse with a written revocation.

Parent/Guardian Signature: __________________________________ Date: ________________________