CARROLL LUTHERAN SCHOOL INHALER FORM

Name: _____ Allergies: _____ Grade/Teacher: _____

Medication: _____ Strength: _____ Dosage: _____ Time: _____

From: _____ To: _____ Reason: _____ Side Effects: _____

Inhaler Release: (It is the student's responsibility to report usage to the office) (Minimal age for student to carry inhaler is 7 years).
This section must be completed for those students who request permission to carry their own inhaler or the use of the inhaler in the office that parents have brought in. We acknowledge that the student named above has been instructed as to the proper use, understands the purpose and the appropriate method as well as the frequency of use of their inhaler. We request that the student may be able to carry their inhaler. The inhaler may also be stored in the school office.

Parent/Guardian Signature: _____ **Physician Signature:** _____

MEDICATION ADMINISTRATION

DATE	MEDICATION	MONITORING ADULT	OBSERVATIONS