Okeechobee County School Health Services
PHYSICIAN'S AUTHORIZATION FORM
Asthma Medication

Name of Student/Patient: ___________________________ **DOB:** ___________ **Date:** ______________

Part I: To be completed by physician's office

It is necessary for the medication listed below be given during school hours:

[ ] INHALER ORDERS

Medication Name: ____ **Dosage**: _______________________
Schedule (how often or what time): ____

If inhaler is being ordered "as needed", please specify under what conditions (**check all that apply**):
[ ] Shortness of Breath [ ] Coughing [ ] Wheezing [ ] Other __________________________

PLEASE CHECK ONE: [ ] Student may carry inhaler [ ] Inhaler to be kept in clinic

____________________________ ______________________________ _____________________
Physician Name (please print) Physician Signature Office Number

[ ] NEBULIZER ORDERS

Medication Name: ____ **Dosage**: _______________________
Schedule (how often or what time): ____

If nebulizer is being ordered "as needed", please specify under what conditions (**check all that apply**): [ ] Shortness of Breath [ ] Coughing [ ] Wheezing [ ] Other __________________________

____________________________ ______________________________ _____________________
Physician Name (please print) Physician Signature Office Number

Part II: To be completed by Parent/Guardian
I HEREBY GIVE PERMISSION (POR LA PRESENTE DOY PERMISO):

- For my child named above to receive medication during school hours. A licensed physician has prescribed this medication. To the school nurse to share information with appropriate school staff relevant to the prescribed medication administration as he/she determines appropriate for my child's health and safety. To the school nurse to contact the above health care provider for information relevant to the prescribed medication administration as he/she determines appropriate for my child's health and safety.

*Para que mi hijo nombrado anteriormente reciba medicamentos durante el horario escolar. Un médico con licencia ha prescrito este medicamento. A la enfermera de la escuela para compartir información con el personal escolar apropiado relevante para la administración de medicamentos prescritos, ya que determina apropiado para la salud y seguridad de mi hijo. A la enfermera de la escuela que se ponga en contacto con el proveedor de atención médica anterior para obtener información relevante para la administración de medicamentos prescrita, ya que determina apropiada para la salud y seguridad de mi hijo.

___________________________________ ____________________ ___________________
Parent/Guardian Signature (Firma del Padre/Tutor) Telephone Number (número de teléfono) Date (Fecha)

Part III: School Use Only
Reviewed by: ____ __________________
School Health Personnel Date

ATTENTION: Please remember to pick-up student medication(s) by the last day of school, all remaining medications will be disposed of per school policy

For School Nurse/MD Office Use: Return to ________________________ *at School* _______________________
Fax number ______________________________

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