



Parent/Physician Request for Self-Administration of Prescription Metered-Dose Inhaler (MDI)

*A separate request form is to be completed for each medication.

Date of Request: _____ School: _____ School Year _____

Student's Name: _____ Teacher/Grade: _____

Medication: _____ Dosage: _____

Times to be Administered: _____ Dates to be Administered: _____

The purpose of the medication is: _____

Special Instructions/Precautions/Side Effects of medication on the above named student.

TO BE COMPLETED BY THE PHYSICIAN

My signature below indicates that:

- 1) The student indicated above has asthma.
- 2) I have instructed the student indicated above in the procedure to use his/her MDI and it is my professional opinion that this student is capable of carrying and self-administering the medication indicated above while on school property or at school-related events.
- 3) The student indicated above has my permission to self-administer the medication as directed above, in a properly labeled container, at the times and dosages as indicated above.

I understand that RISD reserves the right to require that this medication be kept in the clinic if in the school nurses judgement, the student cannot or will not carry the medication in a safe manner and properly self administer the medication.

I understand that the parent's signature in the box below gives permission for the appropriate school staff to contact me in order to obtain medical information/records

I also understand that my written request is valid for one school year and must be renewed at the beginning of each school year.

Physician's Name: _____ Phone Number: _____

TO BE COMPLETED BY THE PARENT

My signature below indicates that:

- 1) I give permission for my child to carry and self-administer the medication specified above on school property or at a school-related event or activity according to the physician's request and the RISD medication guidelines.
- 2) I give my permission for appropriate school staff to contact the physician indicated below to obtain medical information/records.

Parent/Guardian Signature: _____ E-Mail: _____

Parent/Guardian Home Phone: _____ Work Phone: _____