



Parent/Physician Request for Self-Administration of Prescription Metered-Dose Inhaler (MDI)
Petición del Padre/Doctor para el Auto Suministro del Inhalador de Dosis Prefija

*A separate request form is to be completed for each medication. *Se necesita una forma por cada medicamento

Date of Request: _____ School: _____ School Year _____
Fecha de Petición Escuela Año Escolar

Student's Name: _____ Teacher/Grade: _____
Nombre del Estudiante Maestra/Grado

Medication: _____ Dosage: _____
Medicamento Dosis

Times to be Administered: _____ Dates to be Administered: _____
Frecuencia de suministro Fechas de Suministro

The purpose of the medication is: _____
El propósito del medicamento es

Special Instructions/Precautions/Side Effects of medication on the above named student.
Instrucciones Especiales/Precauciones/Efectos Secundarios del Medicamento para el estudiante mencionado arriba: _____

TO BE COMPLETED BY THE PHYSICIAN (PARA COMPLETAR POR EL DOCTOR)

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: _____ Signature: _____ Date: _____

PARA COMPLETAR POR LOS PADRES (TO BE COMPLETED BY THE PARENT)

Mi firma a continuación indica que:

- 1) Yo doy permiso para que mi hijo(a) mantenga con el/ella y se suministre a si mismo(a) el medicamento mencionado arriba cuando se encuentre en la escuela o en actividades o eventos relacionados con la escuela en acuerdo con recomendaciones del doctor y las guías de medicamentos de RISD.
- 2) Yo doy permiso para que el personal designado de la escuela se comuniqué con el doctor que se indica arriba para obtener información/registros médicos.

Firma del Padre/Guardián: _____ E-Mail: _____

Teléfono del Padre/Guardián -Casa: _____ Trabajo: _____ Cel: _____