



**Howard-Suamico School District**  
Authorization to Administer  
**INHALED MEDICATIONS**  
(Use a separate authorization form for each medication)

Student: \_\_\_\_\_ DOB: \_\_\_\_\_  
School: \_\_\_\_\_ Grade: \_\_\_\_\_

**FOR COMPLETION BY PHYSICIAN**

Name of Medication: \_\_\_\_\_

Delivery of Medication:  Inhaler  Spacer  Nebulizer

Dosage: \_\_\_\_\_

Administration:  Daily/Scheduled. Time: \_\_\_\_\_

As needed: Indication for use: \_\_\_\_\_

If needed, how soon can administration of inhaled medication be repeated? \_\_\_\_\_

Inhaled medication cannot be repeated more then: \_\_\_\_\_

Side effects/comments: \_\_\_\_\_

Student is knowledgeable about his or her inhaled medication?  yes  no

Student demonstrates proper technique in administering inhaled medication?  yes  no

Student needs assistance/supervision in administer inhaled medication?  yes  no

I authorize student to carry and administer inhaled medication by him/herself?  yes  no

Physician's Name: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

\_\_\_\_\_  
Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Fax completed signed form to 920-662-7900 – Pupil Services*

**FOR COMPLETION BY PARENT/GUARDIAN**

I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.

I authorize student to carry and administer inhaled medication by him/herself?  yes  no

Parent/Guardian Phone #1 \_\_\_\_\_

Parent/Guardian Phone #2 \_\_\_\_\_

Parent/Guardian Name (print) \_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Parent: Return completed signed form to school office.*