

**Medication Administration in School or Child Care
Nebulzer treatments or inhaled medications**

Parent or Guardian Permission

The parent/guardian of _____ ask that school/child care staff give the
(Child's name)

following medication _____ at _____
(Name of medicine and dosage) (Time)

to my child, according to the Health Care Provider's signed instructions on the lower part of this form.

- ◆ The Program agrees to administer medication prescribed by a licensed health care provider.
- ◆ It is the parent's responsibility to furnish the medication and equipment and to keep daily emergency contact information up to date.

By signing this document, I give permission for my child's health care provider/clinic to share necessary information regarding the care of my child's health condition with Program staff.

Parent/Legal Guardian's Name

Parent/Legal Guardian Signature

Date

Home Phone

Work Phone

Health Care Provider Authorization

Child's Name _____ Birthdate: _____

Name of inhaled medication: _____

Dosage: _____ *Circle one why given: wheezing, coughing, shortness of breath - difficult breathing -*

To be given in school/child care at the following time(s): _____ *my report every 4 hours*

Note to health care provider: Specific time and/or interval must be indicated on this form in order for non-medical persons in school/child care to administer medication

Start Date: _____ End Date: _____

Usual (baseline) respiratory rate for this child: _____

Comments: _____

Seek Emergency Medical Care if the child has any of the following:

- ◆ Respiratory rate greater than _____
- ◆ Coughs constantly
- ◆ Hard time breathing with:
 - ✓ Chest and neck pulled in with each breath
 - ✓ Struggling or gasping for breath
- ◆ Trouble walking or talking
- ◆ Lips or fingernails are grey or blue
- ◆ Other _____

Signature of Health Care Provider with Prescriptive Authority _____ Phone _____

Physicians telephone # _____ Fax # _____