PHYSICIAN’S ORDERS FOR SELF–ADMINISTRATION OF
INHALER BY STUDENT AT SCHOOL
http://www.flsenate.gov/Laws/Statutes/2010/1002.20

SPECIAL NOTE: The physician’s orders must be accompanied by signed parental authorization form.

To: The Physician

The information requested below is needed if a student is to use an inhaler in a Hillsborough County Public School. We appreciate your assistance in this matter. If you would like to discuss this procedure with a School Health Services staff member, please call 273-7020.

Health problem requiring inhaler

Name of medication

Amount to be given

When/how often

What other emergency procedures should be instituted if inhaler proves ineffective

It is understood that school personnel will not be responsible or liable for the administration of the medication listed above. It is further understood that proper instruction in the use of the inhaler has been given to the parent and student by you/your staff. The privilege of self-administration of medication can be withdrawn if abused by the student.

Physician’ Signature: ____________________________ Date: _______________________

Physician’s Printed Name: ____________________________ Phone #: __________________

FS 1002.20
(h) Inhaler use.—Asthmatic students whose parent and physician provide their approval to the school principal may carry a metered dose inhaler on their person while in school. The school principal shall be provided a copy of the parent’s and physician’s approval.

Distribution: Principal, Nurse, Area Director, Student Services
PARENTAL AUTHORIZATION FOR STUDENT TO SELF-MEDICATE (Part F, Item 6)
http://www.flsenate.gov/Laws/Statutes/2010/1002.20

Date ______________________________
Student’s Name ___________________________ Date of Birth _______________ Student # ___________
Teacher’s Name ___________________________ Grade/Homeroom _______________

As the parents/guardians of the student named above, we/I authorize her/him to take (self-administered) the following medication at school:

Name of medication ________________________________________________________________

Amount/Dosage ___________________________________________________ Expiration Date ____________

Time student will take medication ______________________________________________________

Date medication will start ___________________________________ To end ______________________________

Physician’s Name ________________________________________________________________

Health Problems requiring medication ______________________________________________________

Possible reactions/side effects __________________________________________________________

Where medication will be kept at school: ____________________________________________________

It is understood that school personnel will not be responsible or liable for the administration of the medication listed above. It is further understood that the authorizing physician has given proper instruction in the use of the inhaler to parent and student. Permission is also granted for school personnel to contact the physician if there are questions or concerns about the medication. We/I are aware the privilege of self-administration of medication can be withdrawn if abused by theee student.

_________________________________________  ____________________________  ____________________________
Parent/Guardian Signature  Daytime Phone  Evening Phone

_________________________________________  ____________________________  ____________________________
Parent/Guardian Signature  Daytime Phone  Evening Phone

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