Return to School Nurse
Tri-County Area School District
409 S. West St.
Plainfield, WI. 54966

Code #453.04 Exhibit 4

Phone: 715-335-6366
HS ext. 4910 Fax: 715-335-6322
ES ext. 2910 Fax: 715-335-6364

Request form for inhaler use

Student:_____ DOB:_____Grade_____

Parent(s)/Guardian_____ Phone: (H)_____

Address:_____ (W)_____

_____

Management Plan: Check the triggers that bring on the asthma episode for the above student.

__ Exercise __ Strong odors/smoke __ Respiratory infections __ Pollens

__ Change in temperature __ Molds __ Animals __ Dust

___Food_____ __ Other_____

Medication Plan:

Name: Dose: When & How often to use

1. _____

2. _____

3. _____

Asthma Medication or Inhalers:

( ) I have instructed _____in the correct way to use his/her medication. It is my professional opinion that this student is capable and responsible for self -administering the medication.

( ) It is my professional opinion that _____should not carry his/her inhaler medication by him/herself.

_____ _____

Date Physician/Licensed Medical Provider's Signature

Parent/Guardian: Please sign below.

I hereby give permission for (name of child) _____ to receive or use the medication according to the directions state above. I hereby give my permission to the school nurse/school personnel to administer the medication to my child according to the above instructions of the licensed medical provider. I also hereby give my permission to the school nurse/personnel to contact the licensed medical provider if needed. I further agree to hold the Tri-County School District and school nurse/personnel harmless in any and all claims arising from the administration of this medication at school.

Date:_____ Signature:_____

Board approved 2/24/2016