

CATHOLIC DIOCESE OF TOLEDO
ST. MICHAEL SCHOOL
FINDLAY, OH

SELF MEDICATION FOR ASTHMA INHALERS
(Authorization Form)

MUST BE READ AND COMPLETED BY PARENT/GUARDIAN AND STUDENT

_____ has been instructed in the proper use of
(name of student)

_____ inhaler. We request that he/she be
(name of medication)

permitted to carry the inhaler on his/her person or keep in his/her book bag, as we consider him/her responsible. He/she has been instructed in and understands the purpose and appropriate method and frequency of use of this inhaler. He/she also understands this inhaler is not to be shared or used by others. I also understand that my child will not be monitored when using this inhaler nor will a specific record of its use be kept.

I authorize school personnel to allow use of this above medication to the above named child as ordered by our health care provider. I also authorize the school nurse to consult with the health care provider about my child's medication needs. I will see that my child's inhaler is properly labeled with the name of the medication and my child's name.

I understand that the student is responsible for the proper maintenance and use of the medication. I understand that if the student is found to have shared his/her inhaler with other students, or otherwise abused the medication or device, the student will not be permitted to carry his/her inhaler at school and disciplinary action may also occur. I understand, and have informed the student, that he/she must immediately notify the school bus driver, school principal, school nurse, or teacher if his/her inhaler is lost or taken from him/her by another person.

In consideration of the administration of medical services as requested and authorized by this form, I/we, or myself/ourselves, and my/our heirs, executors, administrators and assigns, do hereby waive, release and forever discharge and agree to indemnity and defend the School and the Diocese of Toledo, their members, officers, administrators, employees, servants and agents from and against all claims, demands, or causes of action by any person or entities, for loss, cost, injury, or damage whatsoever arising from or claimed to arise from or in any way connected with the administration of authorized medical services to the student named above.

As **Parents/Guardians** of the child named above **I/We acknowledge that I/We have read and understand** the above statements. As the **student** named above, I **have read and understand** the above information and the responsibility I assume in keeping the above named medication on my person.

PARENT/GUARDIAN _____
(Signature) (Date)

STUDENT _____
(Signature) (Date)

Reverse side must be completed by physician