DIOCESE OF MANCHESTER
REQUEST FOR APPROVAL
TO USE AND POSSESS ASTHMA INHALER

PLEASE PRINT LEGIBLY

PUPIL NAME ______________________________________ DATE ________________

PUPIL DOB ____ GRADE ______________

FOR COMPLETION BY THE PHYSICIAN*

A.	**PUPIL'S NAME**		
B.	**LICENSED PRESCRIBER NAME, ADDRESS, TELEPHONE NUMBER, AND EMERGENCY NUMBER**		
C.	**NAME, ROUTE, AND DOSAGE OF MEDICATION**	**D.**	**FREQUENCY AND TIMING OF MEDICATION ADMINISTRATION**
E.	**DATE OF THE ORDER**		
F.	**DIAGNOSIS AND ANY OTHER MEDICAL CONDITION(S) REQUIRING MEDICATION, IF NOT A VIOLATION OF CONFIDENTIALITY OR IF NOT CONTRARY TO THE REQUEST OF THE PARENT OR GUARDIAN TO KEEP CONFIDENTIAL.**		
G.	**SPECIFIC RECOMMENDATIONS FOR ADMINISTRATION**		
H.	**SIDE EFFECTS, CONTRAINDICATIONS, OR ADVERSE REACTIONS**		
I.	**REQUIRED MEDICATION**		
J.	**EMERGENCY TELEPHONE NUMBER FOR PARENT OR GUARDIAN.**		

This pupil has the knowledge and skills to safely possess and use an asthma inhaler in a school or camp setting.

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PHYSICIAN SIGNATURE **DATE**

*The term "physician" includes any health care practitioner with the authority to write prescriptions.

FOR COMPLETION BY PARENT/GUARDIAN

I request that my child/ward be allowed to possess and use an asthma inhaler at school/camp or at any school/camp-sponsored activity, event or program. S/He has the knowledge and skills to safely possess and use an asthma inhaler. The treating physician attests to this knowledge and skill.

PARENT/GUARDIAN NAME (PRINT)____

PARENT/GUARDIAN SIGNATURE ____

STUDENT SIGNATURE ____

DATE _____________________

TWO SIDED FORM