THE SUMMIT
ACADEMY

7124 Salem Fields Blvd. PMB #157 · Fredericksburg, VA 22407
540-846-2673 · www.thesummitva.org

FOR OFFICE USE ONLY Received: Date medication received: _____ Signatures complete: Inhaler labeled: Student initial (last name):

2nd Inhaler labeled Employee initials: _____ Expiration date: _____

The Summit Academy Inhaler Authorization 2018 – 2019

Student Name (Last, First, Middle)

_____

Date of Birth _____

Allergies _____

PART 1 TO BE COMPLETED BY PARENT OR GUARDIAN I hereby request designated school personnel to administer an inhaler as directed by this authorization for the 2018 – 2019 academic year. I agree to release, indemnify, and hold harmless The Summit Academy, the designated school personnel, or agents from lawsuits, claim expense, demand or action, etc., against them for helping this student use an inhaler.

Inhaler: Renewal New (If new, the first full dose must be given at home to assure that the student does not have a negative reaction.)

First dose was given: Date_____ Time_____

_____

Parent or Guardian Name (Please Print) Parent or Guardian Signature Date

PART Il AND III: TO BE COMPLETED BY LICENSED HEALTH CARE PROVIDER (LAY LANGUAGE, NO ABBREVIATIONS) PART II DIAGNOSIS:

_____

LIST TRIGGERS:

_____

SIGNS / SYMPTOMS:

_____

MEDICATION AND ROUTE:

_____

DOSAGE TO BE GIVEN AT SCHOOL INTERVAL FOR REPEATING DOSAGE:

_____

TIME TO BE GIVEN: _____

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COMMON SIDE EFFECTS: _____

EFFECTIVE DATE: _____ Start: _____

End: _____

PART III This patient has received information on how and when to use an inhaler and that he or she demonstrates its proper use. Please check either a or b below:

a. The patient is to carry an inhaler during school and during sanctioned events. An additional inhaler, to be used as backup, is needed at the SCHOOL OFFICE in an approved school medication locked box.

b. It is not necessary for the student to carry his/her inhaler during school, the inhaler can be kept in the SCHOOL OFFICE in an approved school medication locked box.

_____

Licensed Health Care Provider (Print)

_____

Licensed Health Care Provider Signature Phone Date