

Chester County Intermediate Unit

Permission to Carry an Inhaler

Dear Parent/Guardian,

We are concerned about the safety and well being of the students who have been identified as having asthma. It is important that they have access to the medication necessary for controlling the symptoms of asthma as quickly as possible. Please indicate below how you would like the administration of your child's inhaler handled at school.

Student's Name _____ Birthdate _____ Grade/ Homeroom: _____

Name of Inhaler Medication: _____

Time to be Taken _____

Peak Flow Zones: Green _____ Yellow _____ Red _____

Dose _____

Name of Second Inhaler Medication: _____

Time to be Taken _____

Peak Flow Zones: Green _____ Yellow _____ Red _____

Dose _____

**PLEASE NOTE THAT INHALERS WILL ONLY BE PERMITTED TO BE USED ACCORDING
TO PACKAGE DIRECTIONS OR DOCTOR'S NOTE**

I GIVE MY PERMISSION FOR THE FOLLOWING:

Yes No

_____ _____ After the school nurse has verified proper technique, my child may carry his/her own inhaler and will be responsible for having it with him/her at all times. After use, my child will report to the school nurse to monitor the medication's effectiveness.

_____ _____ My child's inhaler should be kept in the nurse's office in a locked cabinet and the student may have a pass stating that they are to be allowed to come to the nurse's office as needed.

Parent Signature: _____ Date: _____

Physician Signature: _____ Date: _____

STUDENT RULES ON INHALER USE

I am responsible to take my inhaler on time.

I am responsible for bringing my inhaler to school.

I will never touch anyone else's inhaler.

I will never loan my inhaler to anyone else or invite anyone to try it.

Student Signature: _____ Date: _____