Santa Cruz Valley Unified School District # 35

Authorization for Administration of Inhaled Asthma Medication

School: _____

Student's Name: (First/MI/Last) _____

Sex: (please circle) Female Male Birthdate: ____/____/____

FOR COMPLETION BY THE PARENT

Mother's Name: _____

Father's Name: _____

Mother's Work Telephone: _____ Father's Work Telephone: _____

Home Telephone: _____ Emergency Number: _____

Physician's Name: _____ Physician's Number: _____

Is the child authorized to carry and self-administer inhaled asthma medication?

____ YES ____ NO

Authorization is hereby granted to release this information to appropriate school personnel and classroom teachers.

Parent/Guardian Signature & Date: _____

Comments: _____
_____
_____