MAS Integrated School, MASIS Inc.
4524 Bianca's Convention Center Suite #5
Añasco, Puerto Rico, 00610-9684

Authorization for Administration of Inhaled Asthma Medication

(Use a separate authorization for each medication)

Student's Name: _____

Sex: ☐ Female ☐ Male Birth date: ___/___/____

FOR COMPLETION BY DOCTOR:

Physician's Name: _____
Telephone Number: _____ Fax Number: _____
Emergency Contact Number: _____
Diagnosis: _____
Name of Medicine: _____
Form: _____ Dose: _____
Is the child knowledgeable about his/her asthma medication? ☐ Yes ☐ No
Has the child demonstrated the proper technique in administering medication? _____
Medicine is administered daily. Time: _____
Medicine is administered when needed. Indications: _____
_____
If needed, how soon can administration of medicine be repeated? _____
The medication cannot be repeated more than _____

Side effects: _____

Comments: _____
☐ I have instructed _____ in the proper way to use his/her inhaled asthma medications. It is my professional opinion that he/she should be allowed to carry and use this inhaled medication by him/herself.
☐ It is my professional opinion that _____ should not be allowed to carry and use this inhaled medication by him/herself.

Physician Signature/Date: _____

FOR COMPLETION BY PARENT:

Mother's Name: _____
Father's Name: _____
Mother's Work Telephone: _____ Father's Work Telephone: _____
Home Telephone: _____ Emergency Number: _____
Is the child authorized to carry and self-administer inhaled asthma medication? _____

As the parent of the above-named student, I ask that assistance be provided to my child in taking the medicine(s) indicated above at school by authorized staff. If self-medicating is allowed or if no authorized staff member is available, I ask that my child be permitted to self-medicate as authorized by myself and my physician. Authorization is hereby granted to release this information to information to appropriate school personnel and classroom teachers.

Parent/Guardian Signature and Date: _____