## Medication Administration in School or Child Care
## Nebulizer treatments or inhaled medications

### Parent or Guardian Permission

The parent/guardian of _____ ask that school/child care staff give the
(Child's name)

following medication _____ at _____
(Name of medicine and dosage) (Time)

to my child, according to the Health Care Provider's signed instructions on the lower part of this form.

- The Program agrees to administer medication prescribed by a licensed health care provider.
- It is the parent's responsibility to furnish the medication and equipment and to keep daily emergency contact information up to date.

**By signing this document, I give permission for my child's health care provider/clinic to share necessary information regarding the care of my child's health condition with Program staff.**

_____ _____ _____
Parent/Legal Guardian's Name Parent/Legal Guardian Signature Date

_____ _____
Home Phone Work Phone

### Health Care Provider Authorization

Child's Name _____ Birthdate: _____

Name of inhaled medication: _____

Dosage: _____

To be given in school/child care at the following time(s): _____

***Note to health care provider:* Specific time and/or interval must be indicated on this form in order for non-medical persons in school/child care to administer medication**

Start Date:_____ End Date: _____

Usual (baseline) respiratory rate for this child: _____

Comments: _____

**Seek Emergency Medical Care if the child has any of the following:**

- Respiratory rate greater than _____
- Coughs constantly
- Hard time breathing with:
  - ✔ Chest and neck pulled in with each breath
  - ✔ Struggling or gasping for breath
- Trouble walking or talking
- Lips or fingernails are grey or blue
- Other _____

_____ _____
Signature of Health Care Provider with Prescriptive Authority Phone