



REQUEST FOR
SELF-ADMINISTRATION OF PRESCRIBED MEDICATION (INHALED)

Student Name _____ Birth Date _____

Dear Doctor: The parents of the above named student have advised us of your request to have their daughter/son carry an inhaler on her/his person to use for the relief of asthmatic symptoms. State law and school board policy requires all medication administered during the school day be stored in the health office and administered only when physician's and parent's forms are on file. Please fill out the below form, if it is your professional medical opinion that this student health requires that he/she carry an inhaler with them at all times.

Medical Doctor's Recommendation

_____, (student name) is under my care for _____.
Her/his condition warrants immediate inhalation of, _____ it is required that this medication be carried on her/his person. This student has demonstrated knowledge of correct dosage and usage. Medication is to be used by the above student as follows: (Please include Dosage, Time/Frequency) _____

Date Started _____ Date treatment ends _____

Medical Doctor's Information

Medical Physician's Printed Name

Address _____ Phone _____ Date _____

Medical Physician's Signature and License Number

Parent/Guardian Request

As the parent/guardian(s) of _____ (student's name) it is requested that the Beverly Hills Unified School District comply with the orders of the above physician. By signing below the parent/guardian(s) acknowledge and consent that this information may be shared with the appropriate District personnel and assume **all responsibility and liability** for the above medication when this student brings this medication onto any Beverly Hills Unified School campus.

Parent/Guardian Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

THIS FORM REQUIRES A MEDICAL DOCTOR'S SIGNATURE