PRINCE GEORGE'S COUNTY PUBLIC SCHOOLS
Department of Health Services

Physician's Authorization For Medication By Inhaler/Mechanical Device

ONE MEDICATION PER FORM

FOR COMPLETION BY PARENT(S)/GUARDIAN(S)

Full Name of Student_____ School Year_____

Name of School_____ Grade_____

- I understand that I must supply the school with the equipment/supplies needed to administer the medication.
- I understand that all medications must be labeled with the name of the medication, name of the student, name of the physician, date, and directions for administration. Prescription medication must be labeled by a registered pharmacist.
- I hereby authorize the medication described below to be administered as directed by my child's physician.
- I understand that the physician will be called if a question arises about my child's medication.
- 911 will be called immediately if there is a problem.

_____ _____
Signature of Parent/Guardian Date

FOR COMPLETION BY PHYSICIAN

1. Name of medication_____ Strength_____
2. Reason for medication_____
   (Describe symptoms: Wheezing ☐, Coughing ☐, Other ☐, Peak flow reading ☐)
3. Type of device_____
4. Specific directions for use_____

   _____

   Is the student capable of self-administering the medication by device? ❒ Yes ❒ No

   Should student carry medication and device with him/her? ❒ Yes ❒ No
5. Dosage of medication_____
   (number of puffs)
6. Time of day medication is to be given_____
   (be specific with time and/or frequency)
7. Date medication began_____ Date medication discontinued _____
8. Side effects_____

_____ _____
Physician's Signature
(Original signature/NO stamps)
Date

_____ _____
Physician's Printed Name
Physician's Address

_____ _____
Physician's Telephone Number
Physician's Address

Reviewed by Health Services Staff _____
Name/Date