Hillsborough County PUBLIC SCHOOLS
Preparing Students for Life

PHYSICIAN'S ORDERS FOR SELF–ADMINISTRATION OF INHALER BY STUDENT AT SCHOOL

Full Name of Student _____

Date of Birth _____ Student # _____

Home Address _____

_____

Parent/Guardian' Daytime Phone _____ Evening Phone _____

http://www.flsenate.gov/Laws/Statutes/2013/1002.20

SPECIAL NOTE: The physician's orders must be accompanied by signed parental authorization form.

To: The Physician

The information requested below is needed if a student is to use an inhaler in a Hillsborough County Public School. We appreciate your assistance in this matter. If you would like to discuss this procedure with a School Health Services staff member, please call 273-7020.

Health problem requiring inhaler _____

Name of medication _____

Amount to be given _____

When/how often _____

What other emergency procedures should be instituted if inhaler proves ineffective _____

_____

_____

_____

Hillsborough County PUBLIC SCHOOLS
Preparing Students for Life

It is understood that school personnel will not be responsible or liable for the administration of the medication listed above. It is further understood that proper instruction in the use of the inhaler has been given to the parent and student by you/ your staff. The privilege of self-administration of medication can be withdrawn if abused by the student.

Physician' Signature: _____ **Date:** _____

Physician's Printed Name: _____ **Phone #:** _____

FS 1002.20
(h)Inhaler use.—Asthmatic students whose parent and physician provide their approval to the school principal may carry a metered dose inhaler on their person while in school. The school principal shall be provided a copy of the parent's and physician's approval.

Distribution: Principal, Nurse, Area Director, Student Services
SB 87035 (Rev. May 2017)

PARENTAL AUTHORIZATION FOR STUDENT TO SELF-MEDICATE (Part F, Item 6)

http://www.flsenate.gov/Laws/Statutes/2013/1002.20

Date _____

Student's Name _____ Date of Birth _____ Student # _____

Teacher's Name _____ Grade/Homeroom _____

As the parents/guardians of the student named above, we/I authorize her/him to take (self-administered) the following medication at school:

Name of medication _____

Amount/Dosage _____ Expiration Date _____

Time student will take medication _____

Date medication will start _____ To end _____

Physician's Name _____

Hillsborough County PUBLIC SCHOOLS
Preparing Students for Life

Health Problems requiring medication _____

_____

Possible reactions/side effects _____

_____

Where medication will be kept at school: _____

_____

It is understood that school personnel will not be responsible or liable for the administration of the medication listed above. It is further understood that the authorizing physician has given proper instruction in the use of the inhaler to parent and student. Permission is also granted for school personnel to contact the physician if there are questions or concerns about the medication. We/I are aware the privilege of self-administration of medication can be withdrawn if abused by thee student.

Parent/Guardian Signature	**Daytime Phone**	**Evening Phone**
Parent/Guardian Signature	**Daytime Phone**	**Evening Phone**

FS 1002.20
(h)Inhaler use.—Asthmatic students whose parent and physician provide their approval to the school principal may carry a metered dose inhaler on their person while in school. The school principal shall be provided a copy of the parent's and physician's approval.