CONROE
INDEPENDENT SCHOOL DISTRICT

Asthma Medication Permission
Confidential

Entered in eSchool - Date _____ Initials _____

Student's Name _____ Teacher _____ Grade _____

As the Parent / Guardian of the above named child, I give my permission for him / her to be given the medication as described below by whomever the principal designates.

I understand medication will be handled according to recommended Conroe ISD Policy and Procedure, TEA recommendations and FDA Guidelines.

Signature of Parent /Guardian _____ Today's date _____

Daytime Phone _____ Alternate Phone _____

Height _____ Peak Flow Range _____

Inhaler Name of Medication _____ Spacer ____ No spacer ____

Puffs X _____ Time or frequency to be given _____ Daily ___ As Needed ___ From _____ to _____

Special instructions _____ Expiration date on inhaler _____

Nebulizer Name of Medication _____ Diluted – no __ yes ___ with _____

Ampules/ CCs _____Time or frequency to be given _____Daily ___ As Needed ___ From _____ to _____

Special instructions _____ Expiration date on Ampule _____

Changes: Date _____ Puffs X _____ Time _____ or Frequency _____

Date _____ Puffs X _____ Time _____ or Frequency _____

Original prescription ____ Date received _____ Initials _____

Refills: 1 _____ Date received _____ Initials _____

2 _____ Date received _____ Initials _____

3 _____ Date received _____ Initials _____

4 _____ Date received _____ Initials _____