

Inhaler Authorization Form

This form authorizes Merritt Academy to administer an inhaler to your child.

- If inhaler will be administered for 10 working days or less, you do not need a physician's authorization.
 - Manufacturer's instructions for application must be followed unless authorized by child's physician.
- If inhaler will be administered for 11 working days or more, you will need a physician's authorization by signing the form below, sending authorization via fax, or providing written authorization in another format (prescription note, written letter, etc.).

Child's Name:					
Date of Birth:					
Classroom:					
Asthma Severity:		Intermittent or Persistent	If Persistent, please check one:		Mild Moderate Severe
Medication Name:					
Dosage and Times to be Given:					
Any Adverse Reactions:					
Special Instructions (if any):					

Parent Authorization		
Merritt Academy has my permission to administer the medication above.		
_____	_____	_____
(Parent's Signature)	(Printed Name)	(Date)
This medication is effective from: _____ and until _____ or <input type="checkbox"/> August 19, 2020 <small>(first day administered) (last day of 2019-20 program)</small> <i>Authorization may not exceed the last day of the 2019-20 program.</i>		
(Note: If this authorization exceeds 10 working days, your child's physician must provide additional authorization)		

Physician Authorization (only if longer than 10 days)		
I certify that, in my opinion, it is medically necessary that the medication and dosage described above be administered to the child listed above during the hours of operation at Merritt Academy.		
_____	_____	_____
(Physician's Signature)	(Printed Name)	(Date)
This medication is effective from: _____ and until _____ or <input type="checkbox"/> August 19, 2020 <small>(first day administered) (last day of 2019-20 program)</small> <i>Authorization may not exceed the last day of the 2019-20 program.</i>		

FOR MERRITT ACADEMY OFFICE USE ONLY		
Date Received: _____	Office Approval: _____	Medication Expiration Date: _____
Refill Date: _____	Office Approval: _____	Medication Expiration Date: _____