CATALINA FOOTHILLS SCHOOL DISTRICT

HEALTH SERVICES

PERMISSION TO CARRY RESCUE INHALER ON CAMPUS

Student's Name: _____ D.O.B.: _____

Date: _____ Grade: _____ Teacher: _____

School: _____ School Year**:** _____/_____

Student has been instructed in the proper use of:

Name of Medication (include indication, dose & frequency):

_____

Parent Signature & Date:

_____

The medication should be in the original box with the prescription label. The inhaler should also have a prescription label attached to it

_____

Physician Signature & Date

_____

Print Physician Name & Phone Number

Date Form Received by School	# of Metered-Doses Left	Expiration Date