

9th 10th 11th 12th  
Grade Level (Circle One)

## MARIST HIGH SCHOOL PHYSICIAN REQUEST FOR SELF-ADMINISTRATION OF MEDICATED INHALERS

### To be Completed by Parent

I, \_\_\_\_\_, give permission for my child to receive the above medication as directed during the school year.

\_\_\_\_\_  
Parent/Guardian's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Student (Last, First, M.I.)

\_\_\_\_\_  
Date of Birth

### To be Completed by Physician

I am requesting that the above-named student be allowed to self-administer the following medication during school hours or during school-related activities **(for asthma and allergy conditions only)**.

\_\_\_\_\_  
Name of Medication                      Type of Medication (tablet, liquid, capsule, inhaler, injectable)

\_\_\_\_\_  
Dosage                                      Time(s) to be taken or administered

I certify that this student has been instructed in the use and self-administration of this medication and is capable of self-administering the medication independently and without supervision.

Circle One:              Yes              No

\_\_\_\_\_  
Signature of Physician

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Physician

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
Emergency Telephone Number

**Health Form B  
(Return to Health Services)**

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