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 School Year

_____ _____
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

_____
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)