SCOTTSDALE UNIFIED SCHOOL DISTRICT

SCHOOL HEALTH PROGRAM

CONSENT AND RELEASE FOR STUDENT TO CARRY ASTHMA INHALER

School _____ Phone _____

Student _____ Birthdate _____

Name of inhaler(s) _____

The above named student has been instructed in the proper purpose and appropriate method and frequency of use of the listed inhaler(s) We, the undersigned physician and parent of this student, request that he/she be permitted to carry the inhaler on his/her person while at school and during school functions

We understand, confirm and agree that:

1. The Scottsdale Unified School District is not responsible for safeguarding the medication, or for ensuring that the student uses the medication properly;

2. The inhaler must be properly labeled, and the label must clearly reflect the student's name.

3. The physician has explained to the parents and the student the detriments and risks of using the inhaler inappropriately.

5. The student understands his/her responsibility for keeping the inhaler safely on his/her person

6. The student understands the importance of preventing other students from using the medication, that such use could seriously endanger other students, and that voluntarily permitting such use will result in discipline (up to and including expulsion). As a parent, I have discussed these issues with my child and I believe he/she understands his/her responsibilities for safe inhaler use.

7. As a parent, I understand that should my child lose the inhaler, my child is at risk for serious complications.

8. As a parent, I recognize that it is prudent to keep an extra inhaler in the Health Center for emergency use by my child.

9. The student, his/her parent and physician understand that the standard practice of the Scottsdale Unified School District is to keep all medications locked in the school Health Center for the protection of all students

In addition to this form, the District requires that the parent complete and return the medication permission form (HMES 503), explaining how the medication is administered

_____	_____	_____	_____
Physician signature	Date	School nurse signature	Date
_____	_____	_____	_____
Parent signature	Date	Principal/designee signature	Date
_____	_____		
Student signature	Date		

PLEASE NOTE THAT THIS AUTHORIZATION MUST BE UPDATED AND RE-SUBMITTED EVERY YEAR.