Physician Order for
Inhalation Treatment

Name of Student:_____ Birth Date:_____

1. The above student is being treated for: (circle one)

   Asthma Other (specify):_____

2. Name of procedure: **Inhalation Treatment**

   The parent is required to provide the necessary supplies.

3. Procedure Information:

   Name of Medication:_____

   Dosage:_____

   Indication of usage:_____

   When peak flow reading is:_____

The child is knowledgeable about this medication and how to administer it. Yes___No___

The child may self-administer the above medication. Yes___No___

4. The procedure is to be continued as above until:_____.
   Date

All authorizations expire at the end of the current school year.

This procedure will be performed according to KISD protocol unless otherwise specified by physicians' written order.

Physician's Signature:_____ Date:_____

Print Physician's Name:_____ Phone:_____

Parent permission: I hereby request that the treatment specified above be performed to the above-name child. I give permission for the RN to contact the physician in writing or by phone.

_____ _____ _____

Signature of Parent/Guardian Phone Date