



Department of Pediatrics
Division of Pulmonary Diseases

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352-273-8380
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Authorization for Medications to be Taken During School Hours

Student's Name:	DOB
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I request that my child be assisted in taking the medicine(s) described below at school by authorized persons or permitted to medicate herself/himself as authorized by me and my physician. **I permit school staff to discuss this medication with the UF Pediatric Pulmonary staff or the child's pharmacy.**

Parent Signature:	Date:
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Diagnosis for which medication is given:	Asthma
Name of medication	Albuterol
Form:	Metered Dose Inhaler
Dose:	2 puffs
Time medication is to be given	As needed only
Indications for unscheduled medication	Cough, wheeze, shortness of breath
Frequency	Can repeat every 4 hours
Is child authorized to self medicate?	Please supervise
Significant side effects of medication	Rare- Increased Heart Rate, Headaches or Tremor
Length of time this treatment is needed	ongoing

Physician Signature:

Date:

Comments:
If medication is not effective in relieving respiratory distress or does not last at least 4 hours, Contact parents or physician