**PARENTAL/PHYSICIAN AUTHORIZATION FOR STUDENT TO CARRY AND SELF-MEDICATE WITH PRESCRIBED INHALER**

Student's Name: ______________________________ Date of Birth: ________________________________________

School: _____________________________ Grade: _____________ Home Room Teacher: ___________________

List type and dose of inhaler: ___________________________________________

List type and dose of inhaler: __________________________________________

Please check where the medicine will be kept:

__________ Student's Locker
__________ In student's backpack/purse
__________ Other: State location: ____________________________

I understand that the Greeneville City School System shall not be held responsible or liable for the administration of the above listed medication. The parent/guardian releases the school district and its employees and agents from liability for any injury that may result from the student's self-administration of medication. It is the responsibility of the parent/guardian to make sure the child carries the medication on a daily basis as well as on field trips and other off campus activities. It is further understood that the authorizing physician has given proper instruction in the use of the above listed medication(s) to the parent and the student. The privilege of self-administering may be withdrawn if the medication is not used in the proper manner or is left unattended.

________________________________________ ___________________________________
Parent/Guardian Signature Date

Home Phone: __________________________ Work Phone: __________________________

Cell Phone: _____________________________ E-mail address: _________________________

**The following information is required by Tennessee Law TCA 49-5-415**

**Use of Metered Dose Inhaler**

Student Name: _________________________________________ Date of Birth: ___________________________

I certify this child has a health condition requiring the use of a prescribed metered dose inhaler. The parent/guardian and child have been instructed on how to properly use the inhaler.

Name of Medication: _________________________________ Dosage: _____________________________________

Purpose of Medication: ________________________________________________________________________________

When and how often should the child use the inhaler: _______________________________________________________

_____________________________________________________________________________________________________

Length of time medication is required: _____________Entire school year

____________ Enter number of weeks

____________________________________ ____________________ ________________________________
Physician's signature Date Phone