Charleston County School District
Medication/Procedure Doctor's Orders
Metered Dose Inhaler

Name of Student:_______________________________ **Date of Birth:**_________________
Diagnosis: Asthma – Using Metered Dose Inhaler as needed **School:** ______________________

Doctor's orders for medications or procedures at school or school-related functions:

Comments/Special Instructions: ____
____
____
____

Self -Medicating

SELF BRONCHOLDILATOR ADMINISTRATION
Metered dose rescue inhaler ______________________
NAME OF INHALER
(check box if you you agree with the following statements)

€ **This student has been instructed and is knowledgeable of the in the signs and symptoms of asthma [understands indications of respiratory distress, safety precautions, and when to seek assistance].**

€ **This student has been instructed and is competent in proper use of medication(s) noted above (understands indications, actions, side effects, when to take medication, when not to take medication, and when to seek assistance.**

€ **This student should be allowed to possess and self-administer the above medications while in any area of the school; or at any school-sponsored activity; in transit to and from school or school-sponsored activities; and during before-school or after-school activities on school property; or on school-sponsored field trips**

€ **The specific information provided on this form is part of the student's Individual Health Management Plan which I have reviewed and approved.**

______________________________ ______________________________
Legal prescriber (print name and title) **Signature of Legal prescriber**

Office Phone: ______________________ **Date:**______________________

______________________________ ______________________________
Signature of Parent/Legal Guardian **Date**

I have read and understand the CCSD Medication/Procedure policy and I give permission for my child to receive the above medication/procedure as directed.

Charleston County › excellence is our standard
SCHOOL DISTRICT

7/14/2010