

<input type="checkbox"/>	Fennville Public Schools
<input type="checkbox"/>	Hamilton Public Schools
<input type="checkbox"/>	Holland Christian Schools
<input type="checkbox"/>	Holland Public Schools
<input type="checkbox"/>	West Ottawa Public Schools



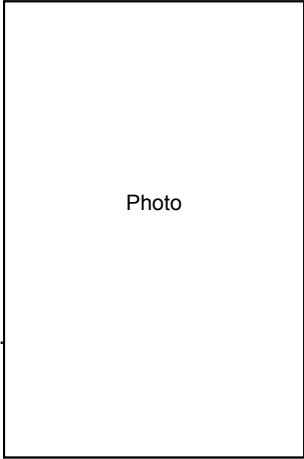
**School Nursing  
Asthma IHP**

Medications may be administered at school by school personnel when necessary for school attendance. This completed form, along with the medication and/or special equipment items are to be brought to the school by the parent/guardian.

**TO BE COMPLETED BY PARENT / GUARDIAN**

I, the parent/guardian of \_\_\_\_\_ date of birth \_\_\_\_\_

request that the building administrator or his/her designee administer the medication or procedure listed below as directed. I give my consent for the exchange of information between the school and my child's health care provider. I give permission to share, if necessary, this information with school personnel who may be involved with the welfare of my child. I fully realize I can withdraw my request/consent in writing at any future date.



As a parent, I understand my responsibilities are:

1. To provide the school with a supply of medication in the original container appropriately labeled by the pharmacy.
2. To provide the school with the written doctor's instructions for medication administration during school hours And that medication will not be administered until signed doctors instructions are at school.
3. To inform the school of any medical changes.
4. To provide the school with this signed consent form annually and when changes in medication occur.
5. I give permission for my child to self administer rescue medication if approved by physician

**Please complete attached asthma action plan from American Lung Association, or submit a current plan already on file in physician office.**

Signature of Parent/Guardian: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date: \_\_\_\_\_

**Physician Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Physician's Name (printed): \_\_\_\_\_

Phone Number: \_\_\_\_\_ FAX Number: \_\_\_\_\_