Loyalsock Township School District

PHYSICIAN'S ORDER FOR ASTHMA INHALER MEDICATION

Name of Student _____

Medication: _____

Strength: _____

Dosage: _____

Time to be Given: _____

Route of Administration: _____

Duration of Order:_____

**Medication may be given 30 minutes before or after time indicated.

Type of Asthma (Bronchial, allergic, exercise-induced): _____

Possible Side Effects: _____
_____

_____Child is knowledgeable about this medication and how to administer it.

_____Child may carry inhaler and self-administer medication.

Physician's Name -PRINTED :_____

Physician's Signature:_____

Date:_____

Phone:_____