

HOLY CROSS LUTHERAN ACADEMY AND PRESCHOOL

Student Nebulizer Authorization

Student Name: _____ Grade/Class: _____

The following information to be completed by the prescribing physician prior to administering medication:

The prescribed nebulizer treatment is necessary to be given to school and during school sponsored activities.	
Diagnosis for medication administration: _____	
Medication to be added to nebulizer: _____	
Frequency for administration: _____	
List any significant side effects related to medication: _____	
Begin date: _____	Stop date: _____ <i>(valid for 1 calendar school year only)</i>
Physician's signature: _____	Date: _____
Please PRINT physician's name: _____	Phone: _____

(Parents must provide tubing, nebulizer chamber, face mask and/or T-piece for student's personal use.)

The following information to be completed by the parent / legal guardian:

This information will remain confidential and only shared with school personnel, as needed, for the student's health and education needs. This authorization includes permission for communication between the school office staff / faculty and my child's health care provider, regarding the medications, if necessary. It is my responsibility to provide Holy Cross Lutheran Academy and Preschool with a new medication authorization form if and when these orders change. I am aware that non-medical personnel may administer this medication. I understand the law provides that there shall be no liability for civil damages as a result of the administration of such medication where the person administering such medication acts as an ordinarily reasonably prudent person under the same or similar circumstances. I also understand that HCLA is not responsible for damage, loss of the equipment, or expenses utilized in this treatment and procedure.

Parent/Legal Guardian signature: _____ Date: _____

Parent/Legal Guardian PRINT name: _____ Relationship: _____