

To be filled out **only if** your child may require **immediate** access to an inhaler to alleviate asthma symptoms or before exercise to prevent the onset of asthma symptoms. (ie. albuterol/proventil inhalers)

INHALER AUTHORIZATION

(Epipen Authorization on Reverse Side)

Part 1 To be completed by the Parent or Guardian

Camp: _____

Child's Name _____
 Last First Sex Date of Birth

Physicians Name _____

Physicians Address _____

 Telephone (business) _____
 Telephone (Emergency) _____

I request that my child be assisted in taking the medicine(s) described below at camp by authorized persons or permitted to medicate her/himself as also authorized by me and my physician (see below).

_____ (_____) _____ (_____) _____
 Date Parent/Guardian Signature Home phone Emergency Phone

Print Name _____

To be completed by the PHYSICIAN:

| | |
|--|-------------------------------------|
| Diagnosis | List Triggers |
| Date of Order | Medication(s): |
| If Medicine is to be given when needed, describe indications: | Form: |
| | Route: |
| List significant side effects/contraindications/adverse reactions: | Dose: |
| | Time interval for repeating dosage: |

I believe that this individual has received adequate information on how and when to use an inhaler and that he or she can use it properly

Please specify if:

The above named individual is to carry an inhaler during their stay at camp. (an additional inhaler, to be used as backup must be kept in the health office or other appropriate location.)

—OR—

The inhaler will be kept in the health office or other appropriate location.

Other information: _____

Date: _____
 _____ (Physicians Signature)