Physician Order for
Inhalation Treatment

Name of Student:_____ Birth Date:_____

1. The above student is being treated for: (circle one)

   Asthma Other (specify):_____

2. Name of procedure: **Inhalation Treatment**

   The parent is required to provide the necessary supplies.

3. Procedure Information:

   Name of Medication:_____

   Dosage:_____

   Indication of usage:_____

   When peak flow reading is:_____

The child is knowledgeable about this medication and how to administer it. Yes___No___

The child may self-administer the above medication. Yes___No___

4. The procedure is to be continued as above until:_____.
   Date

All authorizations expire at the end of the current school year.

5. This procedure MUST be performed by licensed personnel ONLY. Yes___No___

   Be advised that RN's are not in the building every day and some of the procedures are done by trained unlicensed personnel.

This procedure will be performed according to KISD protocol unless otherwise specified by physicians' written order.

Physician's Signature:_____ Date:_____

Print Physician's Name:_____ Phone:_____

Parent permission: I hereby request that the treatment specified above be performed to the above-name child. I give permission for the RN to contact the physician in writing or by phone.

_____ _____ _____

Signature of Parent/Guardian Phone Date