MOLALLA RIVER

AUTHORIZATION FOR NEBULIZED MEDICATION

Student Name:	DOB:

As the parent or guardian of the above referenced student, I request that my child receive the following specialized health services: *Response to significant allergy exacerbation with nebulized medication, per MD order.*

Medication: _____

Dose: _____

Route: Nebulized

For: Asthma exacerbations

I understand that:

- Administration of nebulized medication is done only by designated persons who have completed the required medication training and additional training as described by OAR 581-021-0037
- Orders from a prescribing physician managing the students asthma care must be provided.
- By signing this form, I authorize the exchange of information between the district nurse, school personnel and my child's health care provider for the purposes of asthma management in the school setting.
- This authorization is valid for one year beyond the signed date.
- I am responsible to bring all necessary supplies and medications to school for my student and any medications not picked up by the last day of school will be disposed of.

Signature of parent Date