

WISHING TREE

SHORT-TERM CHILD CARE

Inhaler Authorization

Please read information & procedures on reverse side

Part I Parent or Guardian to Complete

I hereby authorize WISHING TREE personnel to permit the student identified below to use an inhaler in the program or camp as prescribed. I agree to release, indemnify, and hold harmless WISHING TREE and any of their staff members, or directors from lawsuits, claims, expenses, demands, or actions, etc against them for helping this student use an inhaler, provided WISHING TREE staff members are following physicians orders in Part II.

Has the student taken this medication before? Yes No, the first full dose must be given at home to ensure that the student doesn't a negative reaction. First dose was given: Date: _____ Time: _____

Student Name (Last, First, Middle) _____ Date of Birth _____

No WISHING TREE staff shall administer medication or treatment, unless the Program Director or his or her designee has personally reviewed all the required clearances. _____ Parent or Guardian

Signature _____ Daytime Phone Number _____ Date _____

Part II Physician to Complete. Information should be written in lay language with no abbreviations.

Diagnosis	List Triggers
Medications	Dosage to be given at WISHING TREE
Symptoms or activity for which medication is ordered	Time(s) medication is given
Effective date	Time interval for repeating dosage

If the student is taking more than one medication, list sequence in which medications are to be taken

Check the appropriate box:
I believe this student has received adequate information on how and when to use the inhaler and that he or she can use it properly.

The student is to carry an inhaler during WISHING TREE hours with the programs Director's knowledge. An additional inhaler, to be used as backup, may be kept in an approved WISHING TREE location.

The inhaler will be kept in an approved WISHING TREE location (specify) _____

Physicians Name (Print or Type) _____ Physician Signature _____

Student Signature (Required if child carries inhaler) _____ Date _____

Part III Child Care Director to Complete

Check box as appropriate
 Parts I & II above are complete and including signature. (It is appropriate if all items in part II are written on the physician's stationary or a prescription pad.)
 Medication is appropriately labeled. _____ Date by which any unused medication is to be collected by the parent. (Within one week after expiration of the physician order or on the last day of school.)

Child Care Director Signature _____ Date _____