# TIFFIN CITY SCHOOLS
# PHYSICIAN'S VERIFICATION STATEMENT
(Parent Request for Student Possession of Inhalers)

Please **print or type** the following information:

Name of Student________________________________________________
Address______________________________________________________
School_______________________________________________________
Grade________________________________________________________

Name of drug to be administered____________________________________
Dosage_______________________________________________
Time drug is to be administered________________________________
Dates when administration should begin and end:

Beginning Date_____________________________
Ending Date_______________________________

A. Procedures school personnel should follow in the event that the asthma medication does not produce the expected relief from the student's asthma attack.

____________________________________________________________
____________________________________________________________
____________________________________________________________

B. Severe reactions that may occur to the student using the inhaler that should be reported to the physician.

____________________________________________________________
____________________________________________________________
____________________________________________________________

C. Severe reactions that may occur to another student for whom the inhaler is not prescribed should he/she receive a dose of the medication.

____________________________________________________________
____________________________________________________________
____________________________________________________________

Special instruction, if any_______________________________________
____________________________________________________________

Name of Physician_______________________________________________
Address______________________________________________________
Phone Number__________________________________________________

Emergency Phone Number of Physician_________________________________
Physician's Signature____________________________________________
Date____________________