

Jennelle Schroeder, RN District Nurse Phone: (563) 873-2250 Fax: (563) 873-2371

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**PERMISSION FOR USE OF INHALER OR EPINEPHRINE DELIVERY DEVICE DURING SCHOOL HOURS**

(this section to be completed by student's healthcare provider **ONLY**; healthcare provider **AND** parent signature required)

Student's Name: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher/Advisor: \_\_\_\_\_

Date this form is in effect: \_\_\_\_\_ to \_\_\_\_\_ unless otherwise notified of change by provider.

Student's Health Condition/Reason for Medication: \_\_\_\_\_

Name of Medication: \_\_\_\_\_

Instructions for Use/Dosage: \_\_\_\_\_

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**Please select the option that applies to the student listed above and sign below.**

- The student listed above has received instruction on proper use of their inhaler OR Epinephrine delivery device and may self-administer AND carry their inhaler OR Epinephrine delivery device.
- The student listed above has received instruction on proper use of their inhaler OR Epinephrine delivery device and may self-administer, but with supervision of trained staff.
- The student listed above has received instruction on proper use of their inhaler OR Epinephrine delivery device, but still requires the inhaler or Epinephrine delivery device to be stored in the Nurse's office and used only with staff supervision.

Additional Information: \_\_\_\_\_

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Healthcare Provider Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Starting the 2014-2015 school year, we request that an Emergency Action Plan accompany this signed permission slip. Please complete the appropriate attached form and return to school either with the student or by fax to (563) 873-2371. Thank you for your time and cooperation in providing the school with needed medical information to help ensure the safety and welfare of our students.**

**Jennelle Schroeder, RN- District Nurse**