

**ARCHDIOCESE OF LOS ANGELES**  
Authorization and Permission Form  
For Inhalers to be Carried by Students

Part A, B & C to be completed by a licensed physician  
Part D by parent / guardian

*Please Print*

A. \_\_\_\_\_  
Last Name of Student                      First Name                      Sex                      Date of Birth

\_\_\_\_\_

Diagnosis    Inhaler Prescribed

\_\_\_\_\_

Dosage Prescribed                      Time Schedule at School                      Date of Prescription

\_\_\_\_\_

Length of Time Medication will be Necessary

**B. Physician Recommendations (check where applicable)**

- Notify parent if student misses medication at school
  
- Medication may have adverse effects (explain): \_\_\_\_\_  
\_\_\_\_\_
  
- Special instructions and / or comments: \_\_\_\_\_  
\_\_\_\_\_

**C. Physician Authorization. The student for whom this medication is prescribed is under my care.**

\_\_\_\_\_  
Printed Name of Licenced Physician                      Signature of Licenced Physician

\_\_\_\_\_  
Physician Telephone Number                      Date

**D. Parental / Guardian Permission for Medication to be Taken During School Hours**

I request that my child, \_\_\_\_\_, be permitted to receive and be assisted / supervised in taking the above-prescribed medication at school. I will comply with the policies and procedures determined by the Department of Catholic Schools.

\_\_\_\_\_  
Date                      Day Telephone                      Primary Emergency Contact Number

\_\_\_\_\_  
Signature of Parent / Guardian