CHICAGO PUBLIC SCHOOLS

PHYSICIAN'S REQUEST FOR STUDENT TO CARRY INHALER ON PERSON

Name of Student	Birth Date	ID Number
Address	Telephone Number	Zip Code

The above named student has _____
Name of Disease, condition, or Syndrome

I am requesting that the above named student be allowed to carry their inhaler and Self-administer the following medication during school hours. I certify that the above named student has been instructed in the usage and self-administration of the following medication:

Name of Medication	Inhaler

Dosage/frequency of use

He / she understands the need for the medication, and the necessity to report to school personnel any unusual side effects. He/ she is capable of using this medication independently.

The phone number where I may be reached in the event of a reaction to the medication or an emergency is:

Physician's Name_____**Hospital Affiliation**_____
(Please print or type)

Address _____**Telephone #** _____**Fax #**_____

Physician's Signature _____ **Date** _____

***This request is valid for 1 year from date of signature. Any medication change or dose requires a new request form.**