Asthma & Allergy Physicians
Est. 1972

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SCHOOL MEDICATION FORM

Patient Name: _____
Date of Birth: _____

Address: _____
_____

Patient's Weight_____

Name of Licensed Provider: _____

☐ 35 Pearl St.
Suite 300
Brockton, MA 02301

☐ 675 Paramount Dr
Suite 303
Raynham, MA 02767

☐ 888 Washington St
Suite 305
Dedham, MA 02026

☐ 115 Water St
Suite 203
Milford, MA 01757

Medication: ○ Albuterol ○ Ventolin HFA ○ Xopenex HFA

Dosage: 2 puffs

Frequency: ○ q 4-6 hours PRN for wheeze or SOB ○ 10 minutes prior to exercise (e.g.. phys ed and recess)

Route of Administration: Oral Inhalation

Patient's Diagnosis: Bronchial Asthma

Date of Order: _____ Discontinuation Date: _____

Possible Side Effects: increased heart rate, shakiness

Consent for self-administration (provided the school nurse determines it is safe and appropriate)

YES_____ NO_____

_____ _____
Signature of Licensed Provider Date

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