

**FORT WORTH INDEPENDENT SCHOOL DISTRICT  
Health Services Department**

**INHALER(S) ADMINISTRATION REQUEST**

Date: \_\_\_\_\_

School: \_\_\_\_\_

School Year: \_\_\_\_\_

**PARENT REQUEST**

We, the undersigned parents of \_\_\_\_\_ request that our child be allowed to keep the prescribed inhaler(s) on his/her person at all times as requested by the physician.

We understand that it is the student's sole responsibility to keep the inhaler(s) on his/her person. If they are misplaced or used by other students, this privilege will be revoked.

Signature of Parent(s):

\_\_\_\_\_  
\_\_\_\_\_

**PHYSICIAN REQUEST**

You are hereby authorized to allow \_\_\_\_\_ to carry the prescribed inhaler(s) on his/her person at all times.

\_\_\_\_\_  
Name of Inhaler(s)

\_\_\_\_\_  
Dosage and Time of Administration

\_\_\_\_\_  
Signature of Physician

\_\_\_\_\_  
Telephone of Physician

\_\_\_\_\_  
Printed Name of Physician