



Weatherford Independent School District

Health Services

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**INHALER(S) ADMINISTRATION REQUEST**

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

We, the undersigned parents/guardians of \_\_\_\_\_ request that our child be allowed to keep the prescribed inhaler(s) on his/her person at all times and to self-administer medication 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. We also understand that the inhaler(s) must be properly labeled with a prescription label.

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

**PHYSICIAN REQUEST**

You are hereby authorized to allow \_\_\_\_\_ to carry the prescribed inhaler(s) on his/her person at all times and self-administer medication due to the student's asthma.

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

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

Period for which medication will be required \_\_\_\_\_

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

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***Hall Middle School***

**902 Charles Street**

**Weatherford, Texas 76086**

**817-598-2823**

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