**Date:** [Insert Date]

**To:** [Name of School/Organization]
**Attn:** [Health Office/Nurse Name]

**RE: Asthma Inhaler Administration Authorization**

**Student/Participant Name:** [Full Name]
**Date of Birth:** [DOB]

I, [Parent/Guardian Name], hereby authorize the designated staff or school nurse at [Name of School/Organization] to administer the following medication to my child in the event of asthma symptoms or respiratory distress:

- **Medication Name:** [e.g., Albuterol]
- **Dosage:** [e.g., 2 puffs]
- **Delivery Method:** [e.g., MDI with Spacer]
- **Frequency:** [e.g., Every 4 hours as needed for wheezing]

**Self-Administration (Check one):**

[ ] I authorize my child to carry and self-administer this inhaler independently.
[ ] I request that the medication be stored in the health office and administered by staff.

**Emergency Contact Information:**
Name: [Contact Name]
Phone Number: [Phone Number]

I understand that this authorization is valid for the [Year/Term] school year. I agree to provide the medication in its original pharmacy container labeled with the student's name and expiration date.

**Parent/Guardian Signature:** _____

**Physician Name:** [Physician Name]
**Physician Phone:** [Physician Phone Number]
**Physician Signature:** _____