INHALER AUTHORIZATION

I hereby authorize Inquisiminds personnel to against them for helping this student with the inhaler as directed by the parent/guardian. I agree to release, indemnify, and hold harmless Inquisiminds and any of their staff members, or agents from lawsuits, claims, expenses, demands, or actions, etc., against them for helping this student with the inhaler, provided they follow the instructions below. I have read the procedures outlined here on this form and assume responsibility as required. Medication must be properly labeled by a pharmacist.

Student Name (Last, First, Middle)

Date of Birth Date of birth	**Academy Attending** (circle one): Junior, Lower Elem, Upper Elem, Middle School	**Day of Week attending Inquisiminds** (circle one): Tuesday, Wednesday, Thursday, Friday

The Medication and Symptoms or activity for which medication is ordered:

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Directions for use of the inhaler

List triggers
Dosage to be given
Time(s) medication is given
Time interval for repeating dosage

Parent or Guardian Signature	Daytime Telephone	Date