

**AUTHORIZATION FOR DISPENSING MEDICATION  
IN SCHOOL OR CAMP**

**PARENT/GUARDIAN:**

I request that my child \_\_\_\_\_ receive his/her Albuterol as directed in the form below and prescribed by:

\_\_\_\_\_  
Physician's Name

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

Telephone No. \_\_\_\_\_ Date

**PHYSICIAN:**

I request that my patient \_\_\_\_\_ receive the following medication:

**Name of Medication:** Albuterol

**Diagnosis:** Asthma

**Prescribed Dosage:** 2 puffs

**Time to be taken during school or camp hours:**

- 1)  Every 4 to 6 to 8 hrs as needed for dry cough, wheezing, or shortness of breath
- 2)  If checked, also 5 to 15 minutes before exercise

**Expected duration of treatment:** As needed, through the school year or camp session

**Possible side effects and adverse reactions:** Rapid heart rate, hand tremor, nervousness or agitation.

**Other recommendations:** If Albuterol does not provide adequate relief (persistent frequent cough, vomiting with cough, wheezing or shortness of breath) then child must be seen right away by health care provider.

**Print Name:**

**Tel. No:** 617-323-4440

**Signature:** \_\_\_\_\_

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