Little Lungs
OF LONG ISLAND
Pediatric Cough Clinic
Dr. Vicki Masson, MD, FAAP, AE-C

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ALBUTEROL (VENTOLIN® PROAIR® PROVENTIL®) SCHOOL AUTHORIZATION FORM

To be completed by the prescribing healthcare provider.

1. STUDENT INFORMATION

Student Name: _____ Date of Birth: _____ Grade: _____

School: _____

2. MEDICAL INFORMATION

Diagnosis (e.g., asthma, reactive airway disease): _____

Allergies (please list all): _____

3. MEDICATION ORDER

Medication: ☐ Albuterol (Ventolin®) ☐ Albuterol (ProAir®) ☐ Albuterol (Proventil®)

Dose/Instructions:

Inhale 2 puffs every 4 hours as needed for wheezing, shortness of breath, cough, or chest tightness.

☐ Inhale 2 puffs 20 minutes prior to sports or exercise.

Equipment (check all that apply):

☐ MDI with Spacer (Required) ☐ DPI ☐ Nebulizer

Medication Start Date: _____ Medication End Date: _____

(This order is valid for the dates listed above. A new order is required after the end date.)

4. SELF-CARRY / SELF-ADMINISTRATION AUTHORIZATION (NEW YORK STATE)

- I authorize this student to carry and self-administer their albuterol inhaler at school, during *school-sponsored activities,* and on school transportation, in accordance with NYS Education Law § 6809.
- The inhaler must be carried at all times by the student and used as directed.
- A spacer must be used with the inhaler at all times.
- The student has demonstrated the ability and maturity to safely carry and self-administer the inhaler.

APPROVED FOR SELF-CARRY AND SELF-ADMINISTRATION: ☐ **APPROVED** ☐ **NOT APPROVED**

5. EMERGENCY INSTRUCTIONS

If symptoms do not improve after albuterol use, or if the student is in severe distress:

- Notify the school nurse and/or parent/guardian immediately.
- Call 911 if the student has:
  - Trouble breathing that does not improve
  - Blue lips or face
  - Difficulty speaking
  - Severe chest tightness
- Follow the school's emergency action plan.

6. PARENT/GUARDIAN AUTHORIZATION

I give permission for my child to carry and self-administer the above medication as prescribed.

Parent/Guardian Printed Name: _____ Relationship to Student: _____

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Phone Number (best contact): _____

7. PRESCRIBER CERTIFICATION

I certify that the above medication and instructions are necessary for this student and that they have been trained in the correct use of the inhaler with spacer (if indicated).

Physician Printed Name: Dr. Vicki Masson, MD, FAAP, AE-C • NPI: 1598101180

Physician Signature: _____ Date: _____

*This order must be **renewed** at the end of the date listed above.*
NEW ORDERS ARE REQUIRED FOR THE NEXT SCHOOL YEAR.