PEORIA
UNIFIED SCHOOL DISTRICT NO. 11

SMALL VOLUME NEBULIZER FORM

PLEASE COMPLETE THE FOLLOWING FORM AND RETURN IT TO THE SCHOOL NURSE:

Name of Student: _____ Birthdate: _____

Is to receive a small volume nebulizer treatment at: _____ A.M. _____ P.M. _____ Lunch Time

May be repeated at (circle one) 2 hour 3 hour 4 hour None Intervals

With the following medications: ***Medication must be in the prescribed container***

MEDICATION	**DOSAGE**
_____	_____
_____	_____
_____	_____
_____	_____

From _____ Until _____
Date Date

Yes _____ No _____ Small volume nebulizer may be administered at the discretion of: (circle appropriate response)
School Nurse Parents Student

Yes _____ No _____ Please notify parents each time prior to administration of small volume nebulizer

Yes _____ No _____ Small volume nebulizer may be administered for wheezing that is not relieved by the metered dose inhaler

Yes _____ No _____ Small volume nebulizer may be administered prior to P.E./ Athletic competition

_____ _____
Signature of Physician (optional at the discretion of parent/nurse/physician) Date

I wish to have my child receive small volume nebulizer therapy as described above.

_____ _____
Signature of Parent/Guardian Date

COMMENTS: _____
_____
_____