PHYSICIANS INSTRUCTIONS AND RECORD FORM FOR INHALER OR NEBULIZER CARE

A new form must be completed if there are any changes in dosage or frequency of treatments

TO BE COMPLETED BY PEDIATRICIAN:

Physician: _____ Date this form completed: _____
Address: _____
Telephone: _____ Physician's Signature: _____

Name of Inhaled Medication: _____

This medication is to be administered by: (Check **ONE**) ☐Nebulizer ☐Inhaler

Specific indications (such as symptoms) for administering the inhaled medication in accordance with the prescription: _____

Potential side effects and expected response: _____

Dosage: _____

How often is the treatment to be given?: _____

Actions to be taken in the event of side effects or incomplete treatment response. This includes actions to be taken in an emergency: _____

_____

Instructions for proper storage of the medication: _____

Caregivers: Write the date and time treatment was given and sign with your complete signature in the appropriate boxes below.

Date	Time	Signature	Date	Time	Signature