# PARENTAL AUTHORIZATION FOR SELF-ADMINISTRATION OF ASTHMA MEDICATION

Student Name: _________________________ _____________________________ _________________________
Last First Middle

School: ________________________________ Birthdate: _________________ Date: __________________________

Asthma Medication to be Self-Administered: ____________________________________________________________

The following guidelines shall apply to the self-administration of a student's asthma medication:

1) Physician/Prescriber signed, dated authorization to administer the medication, setting for the name and purpose of the medication, the prescribed dosage, time for administration and any other special related information to the administration.
2) Parent (Guardian) signed, dated authorization to administer the medication.
3) The medication is in the original labeled contained as dispensed or the manufacturer's labeled container.
4) The medication label contains the student name, name of the medication, directions for use and date.
5) Annual renewal of authorization and immediate notification, in writing, of changes.
6) The School District and its employees and agents are to incur no liability, except for willful and wanton conduct, as a result from any injury arising from the self-medication of medication by the student.

**PARENTAL AUTHORIZATION**

I hereby acknowledge that I am the parent and/or legal guardian of the above referenced student and that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so, I hereby authorize the School District to allow my child to self-administer his or her lawfully prescribed asthma medication during the following: (1) while in school; (2) while at a school-sponsored activity; (3) while under the supervision of school personnel; and (4) before or after normal school activities.

I further acknowledge and agree that the School District and its employees and agents are to incur no liability, except for willful and wanton conduct by any of the said parties, as a result of any injury arising from my child's self-administration of asthma medication. I further acknowledge and agree that, in absence of willful and wanton conduct on the part of the School District and its employees and agents, I waive any claims that I might have against said parties arising out of my child's self-administration of said medication. In addition, I agree to indemnify and hold harmless the School District and its employees and agents, either jointly or severally, except claims based on willful and wanton conduct of said parties, from and against any and all claims, damages, causes of action or injuries incurred or resulting from my child's self-administration of said medication.

Signature: ______________________________________ ____________________________________________
Parent/Guardian Home Phone

Date: ______________________________________ ____________________________________________
Business / Cell Phone

Signature: ______________________________________ ____________________________________________
Parent/Guardian Home Phone

Date: ______________________________________ ____________________________________________
Business / Cell Phone

**BOTH SIDES OF THIS FORM MUST BE COMPLETED**

**PHYSICIAN AUTHORIZATION AND REQUEST FOR SELF-ADMINISTRATION OF ASHTMA MEDICATION**

_______________________________________ *Student Name*

_______________________________________ *Birth Date*

_______________________________________ *Address*

_______________________________________ *Phone Number*

_______________________________________

_______________________________________ *Emergency Contact Person*

_______________________________________ *Emergency Contact Phone*

TO: PRINCIPAL: _______________________________________

SCHOOL: _______________________________________

The above-named pupil has _______________________________________
*Name of Asthma Condition*

I am requesting that the above-named student take the following medication as prescribed below during school hours (including before after normal school activities, while in a school-sponsored activity and while under the supervision of school personnel).

_______________________________________ *Name of Medication*

_______________________________________ *Type of Medication (Tablet, Liquid or Capsule)*

_______________________________________ *Purpose of Medication*

_______________________________________ *Dosage*

_______________________________________ *Time(s) to be Administered*

_______________________________________ *Special Circumstances Under Which Medication is to be Administered*

_______________________________________ *Possible Side Effects*

I certify that _______________________________________ has been instructed in the use and self-administration
*Name of Student*
of _______________________________________.
*Name of Medication*

He/She understands the need for the medication and the necessity to report to school personnel any unusual side effects. He/She is capable of using this medication independently.

_______________________________________ *Prescriber's Signature*

_______________________________________ *Date Signed*

_______________________________________ *Print Name of Prescriber*

_______________________________________ *Prescriber's Emergency Phone*

_______________________________________ *Prescriber's Address*

**BOTH SIDES OF THIS FORM MUST BE COMPLETED**