Authorization for Self Administration of Medication at School

Name of Student: _____ Birth Date: _____

School: _____ Grade: _____

Asthma & Anaphylaxis Medication	Dosage/Method i.e. pills, inhaler, spray	Frequency	Possible Side Effects	Comments
1.				
2.				
3.				

Other Considerations/Directions: _____

School Year Start Date: _____ School Year Stop Date: _____
(All authorizations expire at the end of the school year.)

□ Student is knowledgeable about the medication and how to administer it.

□ Student has the skills to safely possess and use an inhaler.

□ Student may self-administer the asthma medication.

_____ _____
Printed Name of Physician Physician Signature

_____ _____
Clinic Address Phone Number

_____
Date

Parent/Guardian Authorization

I request that the above medication(s) be given during school hours as ordered by this student's physician/licensed prescriber. I also request the medication(s) be given on field trips or other school sponsored activities, as prescribed.

I release school personnel from liability in the event adverse reactions result from taking the medication(s). I will notify the school of any change in the medication(s) (ex: dosage change, medication is discontinued, etc.).

I give permission for the school nurse to communicate with the student's teachers about the student's medical condition.

I give permission for the school nurse to consult with the above named student's physician/licensed prescriber regarding any question that arises with regard to the listed medication(s).

☐ My son/daughter may self-administer his/her asthma and/or anaphylaxis medication(s).

_____ _____

Parent/Guardian Name Signature

_____

Date

NOTE: Medication is to be supplied in the original/prescription bottle.