REQUEST FOR STUDENT SELF-ADMINISTRATION OF INHALED ASTHMA MEDICATION(S)

Child's Name_____ **School**_____

Date of Birth_____ **Grade**_____

TO BE COMPLETED BY PHYSICIAN:

*Diagnosis*_____

*RX (Dosage/Frequency/Route)*_____

*Adverse Reactions/Side Effects*_____

_____

*List other Medications Currently Being Taken*_____

_____

Student is capable of appropriate and accurate self-administration of his/her asthma medication(s), and should be allowed to carry it for this purpose. ☐ *YES* ☐ *NO*

*Name of Prescribing Physician*_____

*Address*_____ *Phone*_____

*Physician's Signature*_____ *Date*_____

My child has been instructed in the proper use of the above asthma medication(s). I certify that my child is capable of self-administration. I request that he/she be permitted to carry and self-administer the above asthma medication(s). I authorize the release of information between the school and physician pertinent to my child's medication(s) and asthma diagnosis.

My child and I understand that there are serious consequences for sharing any medications with others. Furthermore, I understand that the school shall incur no liability, and I will hold the school and its employees harmless against any claims relating to self administration of asthma medications.

_____ _____

Parent/Guardian Name (please print) *Relationship to Student*

_____ _____

Parent/Guardian Signature *Date*

Self-Administration of Inhaled Asthma Medications Form shall be updated once per school year.