Authorization for Asthma or Anaphylaxis
Self-Administered Medication

Physician/Licensed Health Care Provider Statement

The student, _____, has:

- ◯ Asthma
- ◯ Anaphylaxis
- ◯ Both Asthma and Anaphylaxis

and is capable of self-administering the following prescription medication:

Name and Purpose of Medication: _____

Prescribed Dosage of Medication: _____

Times/Circumstances to Administer: _____

Period of Prescription: _____

_____ _____

Signature of Physician/Licensed Health Care Provider Date

Parental Authorization

1. I, [ ], am the parent or guardian of [ ], and I authorize my child/ward to self-administer the prescription medication identified below while on school property or at a school-related event or activity.

2. I hereby release the District and its employees and agents from liability for injury arising from the student's self- administration of the medication while on school property or at a school-related event unless in cases of wanton or willful misconduct.

3. I understand that if the student identified herein uses the medication in a manner other than prescribed, the student may be subject to disciplinary action by the school. However, any disciplinary action may not limit or restrict the student's immediate access to the medication.

4. I authorize the school nurse to inform appropriate school employees who would have a need to know of the administration of medication (i.e., instructors, teacher aides, school administrators, activity supervisors, bus drivers) that the student may self-administer medication.

5. I give permission for the student to have the prescription medication in their possession while on school property or at a school-related activity or event.

_____ _____

Signature of Parent/Guardian Date

Telephone # _____