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 medicine:

name and purpose of medication _____

_____

prescribed dosage of medication _____

times at which or circumstances under which the medication may be administered

_____

period for which the medication is prescribed _____

_____ _____

Signature of Physician/Other Licensed Health Care Provider Date

PARENTAL AUTHORIZATION

1. I am the parent/guardian of _____ and I authorize my child/ward _____ to self-administer the prescription medication identified above 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 prescription medication while on school property or at a school-related event unless in case 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 (i.e., instructors, teacher aides, school administrators, activity supervisors, bus drivers who would have a need to know) that the student may self-administer medication.
5. I give permission for the student to have the prescription medication with the student while on school property or at a school-related activity or event.

_____ _____

Signature of Parent/Guardian Date