SELF-ADMINISTRATION OF MEDICATION IN SCHOOL

NAME OF STUDENT:_____ GRADE:_____

DIAGNOSIS: _____

MEDICATION:_____

DOSAGE:_____ FREQUENCY: _____

DIRECTIONS:_____

POSSIBLE SIDE EFFECTS: _____

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I certify that this student has asthma or another potentially life-threatening illness and is permitted to self-administer the above medication. He/she has been instructed in the proper techniques of self-administration and has demonstrated competence in this technique.

_____ _____

Signature of Prescribing Physician Date

_____ _____

Address Phone

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I authorize my child to self-administer the above medication. This permission includes self-administration of medication during regular school hours and at other times when my child is participating in a school related event. I understand that the district, school, school nurse and other school employees shall incur no liability as a result of any injury arising from the self-administration of this medication and that I will indemnify and hold harmless the district, school, school nurse and other school employees against any claims arising from the self-administration of medication by my child.

_____

Signature of Parent/Guardian

_____

Date

This permission is effective for the current school year only and must be renewed annually.