



SELF-ADMINISTRATION OF MEDICATION IN SCHOOL (Asthma inhaler only)

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

NAME OF STUDENT: _____ GRADE: _____

DIAGNOSIS: _____

MEDICATION: _____

DOSAGE: _____ FREQUENCY: _____

DIRECTIONS: _____

POSSIBLE SIDE EFFECTS: _____

I certify that this student has Asthma or another potentially life-threatening illness and is permitted to self-administer the above medication. 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

I authorize my child to self-administer the above medication. This permission includes self-administration of medication during regular 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