Authorization for Administration of Medication at School

Name of Student _____ Date of Birth _____

School: Broaddus ISD Grade _____

All Medication Must Be in a Properly Labeled Container and Not Expired

ALL AUTHORIZATIONS EXPIRE AT THE END OF THE SCHOOL YEAR

Please attach an asthma action plan

Asthma Medication	Dosage/Method i.e. pills, inhaler	Frequency	Possible Side Effects	Comments
1.				
2.				

Other Considerations/Directions:

_____

_____

School Year Start Date_____ School Year Stop Date: _____

☐ Student is knowledgeable about the medication and how to administer it.

☐ Student has the skill to safely possess and use an inhaler.

☐ Student may self-administer the asthma medication.

Print Physician Name _____ Physician Signature_____

Clinic Address_____

Phone_____ Date_____

Parent/Guardian Authorization

I request that the above medication(s) be given during school hours as ordered by this student's physician/licensed prescriber. I also request the medication(s) be given on field trips or other school sponsored activities, as prescribed.

I release school personal from liability in the event adverse reactions result from taking the medication(s). I will notify the school of any change in the medication(s).

I give permission for the school nurse to communicate with the student's teachers and staff members about the student's asthma.

I give permission for the school nurse to consult with the above named student's physician/licensed prescriber regarding any questions that arise with regard to the listed medications.

I acknowledge that it may be necessary for the administration of medication to my child be performed by an individual other than a school nurse, and specifically consent to such practice.

____ My son/daughter may self-administer his/her asthma medication.

Parent/Guardian Signature_____ Date_____

Cell_____ Home_____

Please list another ER contact in case we can not reach you.

Contact Name_____ Relation to self_____

Phone _____