AUTHORIZATION ASTHMA OR AIRWAY CONSTRICTING MEDICATION
SELF-ADMINISTRATION CONSENT FORM

PHYSICIAN REQUEST FOR SELF-ADMINISTRATION OF ASTHMA MEDICATION

Name of Student:_____Birthdate:_____Grade:_____

The above-named pupil has asthma.

I am requesting that the above-named student take the following medication during school hours.

_____
(Name of Asthma Medication) (Dosage) (Times to be given during the day)

_____
(Possible Side Effects)

I certify that _____ has been instructed in the use and self-administration
(Name of Student)
of the asthma medication _____ and that he/she understands the need
(Name of Medication)
for medication, and the necessity to report to school personnel any unusual side effects.

_____ _____
Signature of Physician Phone Number of Physician

_____ _____
Print Name of Physician Date

I acknowledge that I agree to have my student self-administer their own asthma medication and that the school district is to incur no liability as a result of any injury arising from the self-administration of asthma medication by the student and that I must indemnify and hold harmless the school district and it's employees and agents against any claims arising out of the self-administration of asthma medication by the pupil. I also acknowledge that I will need to complete this form at the beginning of each school year that the student will be self-administering their asthma medication. I will obtain a written physicians order if the medication is changed or discontinued.

_____ _____
Signature of Parent/Guardian Date

_____
Building