PHYSICIAN REQUEST & PARENT AGREEMENT
FOR SELF-ADMINISTRATION OF ASTHMA MEDICATION

This permission allows the student named below to possess and use his/her asthma medication
1) while in school; 2) while at a school-sponsored activities; 3) while under the supervision of school personnel; or
4) before or after normal school activities, such as before or after school care, on school-operated property.

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Name of Student   Date of Birth   Grade

PHYSICIAN REQUEST (optional)

A PROPERLY PHARMACY-LABELED INHALER BOX IS REQUIRED

The above named pupil has asthma. I am requesting that this student have available and if necessary take the following medication during school hours:

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Name of Asthma Medication   Type of Medication (tablet, liquid, capsule, inhaler)

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Dosage & Times to be taken during the day   Possible Side Effects

I certify that the student named above has been instructed in the use and self-administration of the medication listed above and that he/she understands the need for medication and the necessity to report to school personnel any unusual side effects. He/she is capable of using this medication independently.

Signature of Parent: ______________________________ Date: ____________________

Signature of Physician* ______________________________ Date: ____________________

Print Name of Physician* ______________________________ Phone # ____________________

Address of Physician* ____

*physician, physician assistant, or advanced practice registered nurse

PARENT AGREEMENT (required)

I agree to have my student self-administer his/her own asthma medication and I acknowledge that the school district is to incur no liability, except for willful and wanton conduct, as a result of any injury arising from the self-administration of the medication by my child. I indemnify and hold harmless the school district and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the self-administration of asthma medication by my child.

I give permission for my child ______________________________ to carry the above medication.
I will notify the school of changes in medication and/or in my child's condition.
I will notify the school in writing if the medication is changed or discontinued.
I give permission for the school nurse/building principal to contact the above physician in regard to any medication concerns.
I understand 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.

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Parent/Guardian Signature   Daytime Phone   Date