

SCHOOL MEDICATION FOR ASTHMA AUTHORIZATION FORM
With Parental Permission and Prescription Label Only

Student's Name: _____ **DOB:** _____

The above named student needs the medication for asthma at school that is ordered on the prescription label which I have supplied from (prescriber's name) _____
_____ for _____
dated _____. This is my written authorization as the parent or guardian of the above named student for self-administration of this medication. "Self-administration" means a student's discretionary use of and ability to carry his/her prescribed quick reliever asthma inhaler. "Discretionary use" means that the student has the ability and can demonstrate, if asked, the ability to read his/her name, recognize his/her medication, knows the correct dose (ex., two puffs) and route (ex. Inhaled), and can tell time well enough to know the correct time to self-administer the medication and know when medication is not effective and additional help is needed.

I agree to notify the School Nurse immediately if there is a change in the student's health status, medication/health procedure, or health care provider. I understand that this is effective for the school year for which it is granted and shall be renewed each subsequent school year upon fulfillment of the requirements.

I acknowledge that, when the medication is allowed to be self-administered I waive any claims of liability, except on a claim based on willful and wanton conduct, arising out of the self-administration of said medication. In addition, I agree to hold harmless and indemnify the School District, its employees and agents either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the self-administration or attempts at self-administration of said medication, except on a claim based on willful and wanton conduct.

Parent or Legal Guardian's Signature

Date

pc: parent