Authorization for Administration of Medication at School

Name of Student: _____ Birth Date: _____

School: _____ Grade: _____

Asthma Medication	Dosage/Method i.e. pills, inhaler, spray	Frequency	Possible Side Effects	Comments
1.				
2.				
3.				

Other Considerations / Directions: _____

School Year Start Date: _____ (All authorizations expire at the end of the school year)

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

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

☐ Student may self-administer the asthma medication.

_____

Print Name of Physician Physician's Signature

_____

Clinic Address Phone Number 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 personnel 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) (ex: dosage change, medication is discontinued, etc.).

I give permission for the school nurse to communicate with the student's teachers 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 medication(s).

☐ My son/daughter may self-administer his/her asthma medication (s).

_____

Parent/Guardian Name Signature Date

NOTE: Medication is to be supplied in the original / prescription bottle.

The Asthma & Allergy Foundation of America, Texas
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