AUTHORIZATION FOR SELF-ADMINISTRATION OF MEDICATION (Inhaler)

☐ **This medication will be kept in the office.**

☐ **This medication will be kept with the student.**

Medications will be given at school only with written permission from the child's parent(s) or legal guardian. Prescription medications must have the written permission from the Health Care Provider to administer. The medication must be in the original bottle with pharmacy label as proof of Healthcare Provider prescription. Signed permission will expire at the end of the school year.

_____

I hereby request school personnel to allow my child to self-administer the medication described below:

Student's Name: _____Date of Birth_____

Allergies:_____

This medication has been prescribed for my child by:
Primary Care Provider:_____
Address:_____
Phone Number:_____

I hereby attest that this child has been properly instructed and is competent to administer the following medication:
Name of Medication:_____
Dosage:_____
Time of day for dose:_____
Reason medication is to be given:_____
Possible reactions or side effects (list)_____
_____
Signature of Primary Care Provider: _____Date:_____

I give permission for myself/my child to receive the above medication at school according to school policy and expressly waive any liability on behalf of the school as a result of administration of the above medication. I understand that I have the ultimate responsibility for providing the school with an adequate supply of medication to enable the request for medication to be followed. My signature will give permission for exchange of verbal and written communication between the Healthcare Provider and the school nurse regarding my child's medical regime.

Signature of Parent and Legal Guardian: _____Date_____
Home Phone _____Work Phone_____
Emergency Contact: _____Phone Number:_____