ASTHMA/ALLERGY MEDICATIONS

SELF ADMINISTRATION FORM

PART A: ***Parent/Legal Guardian to Complete*** **– for students K-12**

Name of Student: _____Date of Birth: _____School:_____ Grade: _____

The above student has been instructed on self-administration of medication, and I hereby give my permission for him/her to administer at school as ordered the medication(s) listed below. I understand that it is my responsibility to furnish this medication. I acknowledge that the school incurs no liability for any injury resulting from the self administration of medication and agree to indemnify and hold the school, and its employees and agents, harmless against any claims relating to the self-administration of such medication.

I also acknowledge the need and give permission for appropriate communications between the school health professional and the medical prescriber related to the specific treatment in question, including communication concerning:

1. The prescription or treatment itself (e.g., questions regarding dosage, method of administration, potential drug interactions, size of catheter for emergency insertion in the track of a dislodged gastrostomy tube)
2. Implementation of the treatment in school (e.g., questions regarding safety concerns, infection control issues, or modifications in the treatment order related to the school setting or student's academic schedule)
3. Student outcomes from the treatment (e.g., questions regarding observed side effects, possible untoward reactions, observations of behavior changes in the classroom)
4. Other pertinent issues related to the student's diagnosis, condition, or treatment.

_____	_____	_____
Parent/Legal Guardian Signature	**Parent/Legal Guardian (Printed Name)**	**Today's Date**

PART B: ***Physician to Complete***

Medication	**Purpose**	**Dosage**	**Time / Frequency**
_____	_____	_____	_____
_____	_____	_____	_____

Conditions & Special Circumstances for use: _____

Length of time medication is to be administered: _____

____ This student named above is able to and responsible for self administering the above stated medication as prescribed.

_____	_____	_____
Physician Signature	**Physician (Printed Name)**	**Today's Date**

_____

Physician Phone Number

PART C: ***School Nurse to Complete***

School Nurse Review of order and procedure with the student. Completed _____ _____

Date of Review Nurse's Signature

RETURN TO SCHOOL NURSE

Form Adapted from Olathe Unified School District 233 08/11, Revised 0815
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