China Spring ISD

Medication Administration Request

For Asthma Medications including Asthma Action Plan

DATE_______________________________

NAME OF STUDENT____

CONDITION BEING TREATED ____

NAME OF MEDICATION____

DOSE & ROUTE OF MEDICATION____

TIME MEDICATION TO BE GIVEN____

SPECIAL INSTRUCTIONSOR POSSIBLE REACTIONS____

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Medications given at school may be administered by the school nurse or a medically untrained designate of the school.

____________________________	____________________________
Physician's Printed Name	**Physician's Signature**

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Physician's Telephone Number

I give my permission to school staff to administer the medication as prescribed above.

Parent/Guardian Signature____

Daytime Phone Number____

SELF ADMINISTRATION OF ASTHMA MEDICATIONS:

I HAVE INSTRUCTED THE STUDENT IN THE PROPER WAY TO USE HIS/HER ASTHMA MEDICATION. IT IS MY PROFESSIONAL OPINION THAT HE/SHESHOULD BE ALLOWED TO CARRY &/OR SELF ADMINISTER THE MEDICATION WHILE ON SCHOOL PROPERTY OR AT SCHOOL-RELATED EVENTS.

PHYSICIAN'S SIGNATURE____

I AGREE THAT THE STUDENT IS PROPERLY TRAINED IN THE USE OF HIS/HER ASTHAM MEDICAITON AND REQUEST THAT THE STUDENT BE ALLOWED TO CARRY &/OR SELF ADMINISTER THE MEDICATION WHILE ON SCHOOL PROPERTY OR AT SCHOOL-RELATED EVENTS

PARENT SIGNATURE____

*****If any of the above named medications are to treat or prevent asthma, the emergency plan on the other page must be completed by a physician.**