ASTHMA/EPIPEN PERMISSION FORM

Student's Name_________________________________ Birthdate ____________________

Address______________________________________ Telephone No. _________________

School______________________ Grade________________ Teacher___________________

Please check the administration option below that you prefer for your child.

_____ **Option #1 Inhaler/epipen used in health room**. The student comes to the health room where the inhaler/epipen is kept and uses it under supervision. The advantage is that the medication use will be supervised and records will be kept.

I hereby grant permission for the medication described below to be administered to my child at school.

____ ___________________________

Parent Signature Date

____**Option #2 Student carries inhaler/epipen**. The student will carry the inhaler/epipen. The advantage is immediate accessibility. Under option #2 no records will be kept documenting student use of the inhaler/epipen. If you choose this option it is recommended that you keep a spare in the health room should the student run out or forgets his/her medication. State law requires that the school inform you the school district and its employees are to incur no liability, except for willful and wanton misconduct, as a result of any injury arising from self-administration of medicine by the student.

Parent Signature _____________________________________Date___________________

CONSENT FOR RELEASE OF MEDICATION INFORMATION

I hereby grant permission for the school nurse to exchange information with the treating physician regarding medication administered to my child at school.

Parent Signature ____________________________________ Date____________________

PRESCRIBED MEDICATION INFORMATION

(TO BE COMPLETED BY THE PHYSICIAN)

Diagnosis____

Name of Medication and Dose____

Is this medication necessary in order to maintain the child at school? ___________________

I certify that ____________________________________has been instructed in the use and self-administration of the above named medication. He/she understands the need for the medication, and the necessity to report to school personnel any unusual side effects. He/she is capable of using this medication independently.

Possible side effects:____

Physician's Printed Name__________________________________Date ____________________

Physician's Signature_____________________________________Phone ___________________