ADMINISTRATIVE DIRECTIVE
Effective: November 08, 2004 Revised: June 1, 2005

Hitchcock Independent School District

AUTHORIZATION FOR SELF-ADMINISTRATION OF ASTHMA MEDICATION

Name of student: ____________________________ Teacher/grade: __________________

Name of parent: ____

Parent's contact information: ____

Prescribing health care provider: ____

Contact information for the prescribing health care provider: _________________________

____

Description of condition/reason for medication: _____________________________________

____

Prescribed medication and dosage: ____

How/when the medication should be used at school (dosage, method, times) ___________

____

Anticipated length of treatment: ____

Possible adverse reaction: ____

_____________________________________ (*student's name)* has asthma and is treated with prescription medication. (He) (She) is capable of administering (his) (her) own medication at school and at school-related or school-sponsored activities. The District will be informed of any changes to the medication specified on this form, to the dosage, or to the recommended regimen by an updated version of this consent form.

Parent: ____ Date: ____________

Physician prescribing treatment: _____________________________ Date: ____________