TOMBALL INDEPENDENT SCHOOL DISTRICT

AUTHORIZATION FOR SELF-ADMINISTRATION OF ASTHMA/ALLERGY MEDICATION

Name of student _____Grade _____

Name of parent _____

Home # _____ Work # _____ Cell # _____

Prescribing health care provider _____

Office # _____ Fax # _____

Description of condition/reason for medication _____

Prescribed medication and strength _____

Administration: Dosage _____ Method _____ Time(s) _____

Anticipated length of treatment _____

Possible adverse reaction(s) _____

_____ (student's name) has ____asthma ____allergies that are potentially life-threatening and is treated with prescription medication that must be carried by the student. (He) (She) is capable of administering their 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. The student understands that the intentional misuse of any medication or medical equipment that could knowingly and recklessly cause harm to another student will result in disciplinary action.

Parent _____ Date _____

Health care provider _____ Date _____

Student _____Date _____