



Authorization for Self-Administration of Asthma and/or Anaphylaxis Medication

(please print)

Student Name: _____

Date of Birth: _____

Campus: _____

Grade: _____

Parent/Guardian: _____

Work Phone: _____

Address: _____

Cell Phone: _____

Home Phone: _____

PRESCRIBING PHYSICIAN OR HEALTH CARE PROVIDER RECOMMENDATION

Provider Name: _____

Provider Phone: _____

This Student, _____ has the following health condition(s):

Asthma

Anaphylaxis in response to: _____

He/She has been instructed in proper use of his/her prescribed medication indicated in the table below. In my opinion, he/she is capable of administering his/her own prescription medication at school and at school-related or school-sponsored activities.

List prescription asthma and/or anaphylaxis medication(s) that may be self-administered by the student

Medication Name	Dose	Route	Frequency	Reason (asthma or anaphylaxis)

This authorization is valid through: _____ (date)

Signature of MD/OD/NP/PA Completing this form

Date Signed

PARENT/GUARDIAN AUTHORIZATION

I authorize my child, _____ to self-administer emergency prescription medication as recommended by his/her health care provider above)

I understand my child's medication must have a prescription label indicating his/her name.

If my child is unable to self-administer the medication(s) listed above, I give permission for trained school employees to administer emergency medication in accordance with the prescription label.

I understand that an updated version of this form is required when any changes are made to the medication(s) specified on this form, including dosage.

Printed Name & Signature of Parent/Guardian Completing this form

Date Signed

SCHOOL NURSE ASSESSMENT

In accordance with Texas Education Code 38.015(b)(2), _____ has demonstrated to the school nurse the skill level necessary to self-administer the listed medication(s).

If applicable, he/she has been instructed to notify the school nurse, teacher, coach, athletic trainer, or other nearby district employee following self-administration of an emergency epinephrine auto-injector.

This form is on file in the student's Health Record.

Printed Name & Signature of School Nurse

Date Signed