AUTHORIZATION for **SELF-ADMINISTRATION**
Of **Emergency Asthma/Allergy** Medication

PARENT

Date

Name of Student Date of Birth
School Teacher Grade

The student named above has been instructed on self-administration of medication, has demonstrated proper use of his/her medication, verbalized understanding of known symptoms and triggers requiring use of self-administered medication, and I hereby give my permission for him/her to administer at school as ordered the medication(s) listed below. I understand it is my responsibility to furnish this medication and a back up medication to be kept in the health office. I acknowledge that the school incurs no liability for any injury resulting from the self-administration of medication.
The school nurse or designee has permission to communicate with the doctor or designee and the doctor has permission to communicate with the nurse or designee in relation to the administration of medication/medications listed below.

Parent Signature_____Parent (Printed Name) Today's Date

PHYSICIAN

Medication Dosage Purpose
Time of day medication to be given
Additional circumstances under which medication is needed

Possible side effects
Anticipated number of days to be given at school

MedicationDosage Purpose
Time of day medication to be given
Additional circumstances under which medication is needed

Possible side effects
Anticipated number of days to be given at school

(Student's Name) has been ***instructed*** on self-administration of medication, has ***demonstrated*** proper use of his/her medication, has ***verbalized*** understanding of their known symptoms and triggers requiring use of self-administered medication, and I hereby give my permission for him/her to administer at school as ordered the medication(s) listed above.

Physician Signature Physician (Printed Name) Today's Date

Physician Phone Number Physician Fax Number