PEARLAND INDEPENDENT SCHOOL DISTRICT

School Health Services

Student Self-Administration of Emergency Asthma or Anaphylaxis Medications

Student's Name: _____ Date of Birth: _____ School Year: _____

Texas Education Code § 38.015 and Pearland ISD School Board Policy allows a student with asthma or anaphylaxis to possess and self-administer prescription asthma or anaphylaxis medication while on school property or at a school-related activity, provided that the school has received written authorization from the student's parent and a statement from the student's healthcare provider. The completion of this form will meet these requirements. This statement must be kept on file in the office of the school nurse or principal.

Prescribing Health Care Provider's Authorization

Student's Name: _____, is under my care for the treatment of

❑ **Asthma** ❑ **Anaphylaxis**

❑ It is in my professional opinion that the above-named student **should** be allowed to carry and self-administer the following prescription asthma or anaphylaxis medication(s) while on school property or at a school-related activity. I have instructed the above name student in the proper way to use the following medications.

❑ It is in my professional opinion that the above-named student **should NOT** be allowed to carry and self-administer his/her asthma or anaphylaxis medication(s) while on school property or at school-related activities.

Medication: _____
Purpose: _____
Dosage: _____
When to use: _____
Can be repeated _____times _____minutes apart

Medication: _____
Purpose: _____
Dosage: _____
When to use: _____
Can be repeated _____times _____minutes apart

These medications are prescribed for the time period _____ until _____

Health Care Provider's Signature: _____ **Date**: _____

Health Care Provider's Printed Name: _____ Telephone: _____

Health Care Provider's Address: _____

Parent Authorization

I, _____(parent/guardian), request Pearland ISD to permit my child, _____ to carry and self-administer prescription emergency asthma and/or anaphylaxis medication(s) on school property and at school-related activities according to the licensed health care provider's direction. Any changes to the above medication(s), dosage(s) or recommended regimen will be accompanied by an updated version of this consent. I acknowledge that the school nurse, Pearland ISD staff, the school district, or any of its other agents shall not be responsible or liable in any manner for any claim arising, directly or indirectly, for provision of the services requested.

This form is to be completed each school year.

Parent/Guardian Signature: _____ **Date:** _____

Pearland Independent School District

School Health Services

Self-Carried Asthma or Anaphylaxis Medication Contract

Student: _____ DOB: _____ Grade: _____

Parent Name: _____ Telephone: _____

Physician: _____ Telephone: _____

Medication: _____ Dose: _____ Time: _____

Medication is permitted in accordance with district policy. The student's physician must authorize self-carried, self-administered medication. **A prescription label with the student's name must appear on the medication container.**

Responsibilities for Carrying Emergency Medication

Observed and Completed by RN

Yes	No	
____	____	Health Care Action Plan Complete
____	____	Student demonstrates correct use of prescribed medication
____	____	Student verbalizes proper and prescribed timing for medication
____	____	Student agrees to not share medication with others
____	____	Student agrees to keep medication in an appropriate and safe location
____	____	Student agrees to come directly to the health clinic if symptoms do not improve after using the medication
_____	____	A second labeled container will be kept in the health clinic (recommended, not required)

The student does / does not demonstrate the specified responsibilities. The student may carry the medication unless he/she fails to follow the above agreement.

_____ _____

Student Signature/ Date **School Nurse Signature/ Date**

I give permission for my child to carry the medication specified above. I understand that s/he must follow the responsibilities listed above. I will notify the school of changes in medication or my child's condition and support my child to follow the above agreement. I will be contacted to develop a new plan if the agreement is not followed. I acknowledge that PISD will not be liable for injury arising from the student's possession and self-administration of allergy/asthma medication.

_____

Parent/Guardian Signature and Date

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