



# 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. The 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: _____	Medication: _____
Purpose: _____	Purpose: _____
Dosage: _____	Dosage: _____
When to use: _____	When to use: _____
Can be repeated ____ times ____ minutes apart	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 permit my child, \_\_\_\_\_ be permitted to carry and self-administer prescription emergency asthma 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 \_\_\_\_\_