FORT WORTH INDEPENDENT SCHOOL DISTRICT
Health Services Department

Self- Administration of Prescribed Asthma or Anaphylaxis Medicine by Student

This form is to be completed by the parent and physician/licensed health care provider of students who are to keep prescribed asthma or anaphylaxis medication on their person and self- administer it as prescribed.

School Name: _____ *School Year: _____*

Parent Request

We, the undersigned parents of _____ request that our child be allowed to keep the prescribed asthma or anaphylaxis medication on his/her person at all times and self- administer it as requested by the physician.

We understand that it is the student's sole responsibility to keep the prescription medication on his/her person. If they are misplaced or used by other students, this privilege will be revoked.

I give permission for the school nurse to consult with the above named student's physician/licensed prescriber regarding any questions that arise with regard to the listed medication(s) or medical condition(s) being treated by the medication(s).

_____ _____
Signature of Parent(s) *Date*

Physician Request

You are hereby authorized to allow _____ to carry the prescription medicine on his/her person at all times.

_____ _____
Name of Medication *Dosage and Time of Administration*

Please check all that is applicable.
_____ Student is knowledgeable about the medication and how to administer it.
_____ Student has the skills to safely possess and use the prescribed medication.
_____ Student may self-administer the medication.

All authorizations expire at the end of the school year.

_____ _____
Signature of Physician/Licensed Health Care Provider *Telephone Number*

_____ _____
Printed Name of Physician/Licensed Health Care Provider *Date*

The student has demonstrated the skill level necessary to self-administer the prescription medication including the use of any device required to administer the medication.

_____ _____
Signature of School Nurse *Date*

R6/13/07