Denison Independent School District
School Health Services

Authorization for Self-Administration of Asthma or Anaphylaxis Medication

(*To be completed at the beginning of each school year and kept on file with the campus nurse)*

Name of student_____

Date of Birth _____ Grade_____ Teacher/Homeroom _____

Condition for which medication is being administered _____

To Be Completed by Physician

☐ I have instructed _____ in the proper way to use his/her medications. It is my professional opinion that he/she **should** be allowed to carry and self-administer his/her medication, as prescribed on the Emergency Action Plan, while on school property or at school-related events. His/her parents are aware that there will not be medication available in the school clinic unless they decide to provide extra medication.

☐ It is my professional opinion that _____ **should not** be allowed to carry and self-administer any of his/her medications while on school property or at school related events. It should be kept in a designated area and be accessible to the student.

Physician/Practitioner _____ _____ _____

Printed Name Signature Date

To Be Completed by Parent

I permit my child to carry his/her medication as prescribed on the Emergency Action Plan. I understand that my child, not the school, is responsible for the storage, possession and use of the medication. I understand that sharing medication with other students will result in disciplinary action.

Describe how your child will carry/store their medication(s):

_____

_____

_____ _____ _____

Parent/Guardian Signature Date Phone Number

To Be Completed by Student

I understand the purpose and appropriate use of my medication. I understand that I, not the school, am responsible for the storage, possession and use of the medication. I understand that sharing medication with other students is potentially dangerous and will result in disciplinary action.

Student Signature: _____ Date: _____