Millsap ISD
Authorization for Administration of Prescription Asthma or Anaphylaxis Medication by Student

Name of Student: _____Birthdate:_____

School Year:_____ School: _____Teacher:_____ Grade:_____

Circle One: Epipen Inhaler(s) Nebulizer

Medical Condition	Medication	Dose	Time	Route

Additional information/comments:_____

(All authorizations expire at the end of the school year.)

❑Student is knowledgeable about the medication and how to self-administer it.

❑Student has the skills to safely possess/use this medication.

_____ _____
Print or Type Name of Physician / Licensed Prescriber Signature

_____
Clinic Address Phone Number Date

Parent / Guardian Authorization

1. I request that the above medication(s) be given during school hours as ordered by this student's physician / licensed prescriber. I also request the medication(s) be given on field trips, as prescribed.
2. I release school personnel from liability in the event adverse reactions result from taking the medication(s). The student understands that he/she is not to 'share' the medication.
3. I will notify the school of any change in the medication(s), (e.g. *medication change, dosage change, medication is discontinued, etc*.).
4. I give permission for the school nurse to communicate with the student's teachers about the student's health condition(s) and the action of the medication(s).
5. 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).
6. I give permission for the medication(s) to be given by designated personnel as delegated by the school nurse.

_____ _____
Parent / Guardian Signature Date

Medication MUST be supplied in the original, properly labeled prescription container.