Lenape Regional High School District
Asthma Treatment Plan Parent Permission

These orders remain in effect during the school day, school sponsored activities and school sponsored trips & school sponsored overnight trips

Name _____ Grade _____ DOB _____/_____/_____

Parent Request for Administration of Medication

I request that the medication indicated on the Asthma Treatment plan form be administered to my child. I acknowledge that the school district and its employees or agents shall incur no liability as a result of administration of this medication to my child. I give the school nurse permission to contact the physician and/or pharmacist with any questions concerning the medication.

I give my permission for relevant health information to be shared with teachers/staff.

PARENT/GUARDIAN PRINTED NAME _____

PARENT/GUARDIAN SIGNATURE _____

DATE _____ PHONE ( ) _____ - _____

Parent Consent for Self-Administration of Medication by Student

I am aware that legislation allows students to self-administer medication in the treatment of asthma as long as the physician certifies that the student has been instructed in and is capable of self-administering the prescribed medicine.

I acknowledge that the school district and its employees and agents shall incur no liability as a result of any injury arising from the self-administration of medication by the pupil and agree to indemnify and hold harmless the school district and its employees and agents against any claims arising out of the self-administration of medication by the pupil.

I authorize my student to self-administer the medications certified by the physician for self-administration that appear on Asthma Treatment Plan for the treatment of asthma.

I give my permission for relevant health information to be shared with teachers/staff.

PARENT/GUARDIAN PRINTED NAME _____

PARENT/GUARDIAN SIGNATURE _____

DATE _____ PHONE ( ) _____ - _____