

**ALEDO INDEPENDENT SCHOOL DISTRICT
HEALTH SERVICES
1008 BAILEY RANCH ROAD
ALEDO, TEXAS 76008**



Authorization for Self-Carry/Self-Administration of Emergency Asthma and/or Anaphylaxis Medication

Student Name: _____ Date of Birth: _____
School: _____ Grade: _____ School Year: 20 ____ - 20 ____
Parent Name: _____ Parent Phone: _____
Physician Name: _____ Physician Phone: _____

| MEDICATION ADMINISTRATION INSTRUCTIONS | | | | | |
|---|---------------|--------------------------------|--------------|--|-----------------|
| Medication Name | Dosage | When to Take Medication | Route | Reason for Medication (Diagnosis) | Exp Date |
| | | | | | |
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PHYSICIAN/PRACTITIONER:

I have instructed the above-named student on the proper use of their asthma and/or anaphylaxis medication. It is my professional opinion that the student is capable and should be allowed to self-carry and self-administer the prescribed medication while on school property or at a school-related event.

Physician Signature: _____ Date: _____

PARENT/GUARDIAN:

I give consent for my child to self-carry and self-administer the above asthma or anaphylaxis medication for the current school year. I do hereby release Aledo ISD staff from any liability in connection with the self-administration of this medication. I absolve the school of any responsibility in safeguarding my child's medication. Any changes in medication and/or dosage requires a new authorization form to be filled out and provided to the nurse.

Parent/Guardian Signature: _____ Date: _____