



BCSD Health Services Asthma Authorization Form 2026-2027

THIS SECTION MUST BE FILLED OUT BY A LICENSED HEALTH CARE PROVIDER ONLY - PLEASE PRINT

Student Name: _____ **Birthdate:** _____

List **Known Allergies** and/or **Asthma Triggers** include: _____

Usual asthma symptoms include but are not limited to: _____

Prescribed Rescue Medication: _____ **Spacer Recommended:** No Yes

Prescribed Frequency and Dose:

As Needed for Rescue Treatment Give _____ Puffs

As Needed Before PE/Recess/Strenuous Activity Dose ;Give _____ Puffs (Scheduled Doses should be 4 hours apart)

Sick Plan: Scheduled Rescue Treatment Give _____ Puffs every _____ hours and before PE/Recess/Strenuous Activity

It is the responsibility of the parent to notify the school nurse if the student is on a sick plan & for how long.

For Rescue Treatment:

- Observe student for fifteen minutes after rescue medicine administration or until breathing difficulties are relieved.
- If a student is still experiencing breathing difficulties after 15 minutes:
IT IS **or** IS NOT okay to repeat rescue treatment dose for up to a total of _____ times to relieve breathing difficulties.

Daily Asthma Control Medication(s) prescribed for **at home** use: _____

Student has permission to self-carry / self-administer this medication: No Yes – if yes, read the following carefully:

I agree that this student must be allowed to have the above-named medication/procedure on his/her person during school hours, in transit to and from school or school-sponsored activities, before and after-school activities on school property, and any school sponsored activity. **This child has demonstrated competency in self-monitoring and self-administration of this medication/procedure.** The parent is aware that they cannot hold the school district responsible for any adverse outcome of this action.

Printed Name of Health Care Provider: _____ **Phone:** _____

Health Care Provider Signature: _____ **Date:** _____

Parents / Legal Guardians Please Read Carefully: By signing below, I understand and agree to the following:

- *An Individualized Healthcare Plan (IHP) will be developed for students who have a health condition that necessitates an IHP.*
- *the school district and its employees and agents are not liable for an injury arising from a student's self-monitoring or self-administration of medication.*
- *the parent or guardian indemnifies and holds harmless the district and its employees and agents against a claim arising from a student's self-monitoring or self-administration of medication.*
- *the school district and its employees and agents are not liable for an injury arising from the administration of medication authorized by an IHP.*
- *the parent or guardian shall indemnify and hold harmless the district and its employees and agents against a claim arising from administration of medication authorized by an IHP.*
- *I understand that all prescribed medications must be in the original container issued by the pharmacist with the most recent prescription label.*
- *I will notify the school when the medication is discontinued or the dosage changes.*
- *I give permission for the principal, school nurse(s), and/or health services to share this information with individuals who have responsibility for my child.*
- *I give BCSD Health Services my permission to contact the prescribing Licensed Health Care Provider and prescribing pharmacy in relation to this prescription medication.*
- *I agree to allow my child's medication to accompany the teacher/staff on field trips if medication time coincides with the trip. *
- *I am responsible for replacing medication before the expiration date.*
- *I give my permission for designated BCSD staff to administer this medication to my child according to district requirements*
- *I understand that my child will lose the privilege to self-medicate if he or she endangers him- or herself or another student by misusing the medication(s).*

My student has orders from our health care provider to Self-Carry/Self Administer this Medication: No Yes **** If YES, read the following carefully:****

**Working closely with our physician we have decided to allow my child to self-administer and self-monitor the above medication while at school. My child has been trained by our physician and has demonstrated competency in this procedure. My child must be allowed to possess this medication at school sponsored activities, in transit to and from school or school-sponsored activities, and during before or after-school activities on school property. I realize that the School District of Beaufort County cannot be held responsible for any adverse outcome of this action. I am responsible for replacing expired medication before the expiration date. I will provide the medication in the original container, clearly labeled with my child's name. I will notify the school immediately if the medication is discontinued or the dosage has been changed. Permission is granted to the principal and/or school nurse to share this information with individuals who have responsibility for my child. The first dose will be given at home so that I can monitor adverse reactions. I give the school nurse my permission to contact the physician's office to request medical information concerning my child.*

Parent/Legal Guardian Printed Name: _____ **Daytime Phone Number:** _____

Parent/Legal Guardian Signature: _____ **Date:** _____