SAINT XAVIER HIGH SCHOOL
ASTHMA MEDICATION AUTHORIZATION FORM 2026-2027

This form is mandatory for all students with asthma to administer medications at school. Please fill out and return to the Student Services Office.

STUDENT NAME:_____ STUDENT I.D. #_____
Last First Middle

IF YOUR SON HAS ASTHMA, BUT DOES NOT NEED TO SELF-ADMINISTER ASTHMA MEDICATIONS AT SCHOOL, COMPLETE AND SIGN ONLY THIS SECTION OF THE FORM AND HAVE YOUR SON RETURN THE SIGNED FORM TO STUDENT SERVICES.

I, _____, parent/guardian of the above named student, verify that my son has asthma, but does not need to carry or self-administer any asthma medications at school, at school-sponsored activities or at any time that he is present on Saint Xavier High School's property.

_____ _____
Parent/Guardian Signature Date

IF YOUR SON HAS ASTHMA AND HE MUST SELF-ADMINISTER ASTHMA MEDICATIONS AT SCHOOL, YOU AND THE STUDENT'S HEALTH CARE PRACTITIONER MUST COMPLETE AND SIGN ALL SECTIONS BELOW. YOUR SON MUST RETURN THE COMPLETED FORM TO STUDENT SERVICES BEFORE HE WILL BE GIVEN PERMISSION TO SELF-ADMINISTER HIS ASTHMA MEDICATIONS ON SCHOOL PROPERTY OR AT ANY SCHOOL-SPONSORED ACTIVITY.

I, _____, parent/guardian of the above named student, authorize Saint Xavier High School to allow the student to carry with him and self-administer his asthma medications. I acknowledge that Saint Xavier High School shall incur no liability as a result of any injury sustained by the student from the self-administration of asthma medications. I further indemnify and hold harmless Saint Xavier High School and its employees against any claims relating to the student's self-administration of asthma medications. The permission for self-administration of medication shall be in effect for the school year in which it is granted and shall be renewed each following school year. (KRS 158.834)

_____ _____
Parent/Guardian Signature Date

IF YOUR SON HAS ASTHMA AND HE MUST SELF-ADMINISTER ASTHMA MEDICATIONS AT SCHOOL, THE STUDENT'S HEALTH CARE PRACTITIONER MUST COMPLETE THE FOLLOWING SECTION AND SIGN WHERE INDICATED.

I, _____, Health Care Practitioner of the above named student, verify that this student has asthma, and has been instructed in self-administration of the prescribed medications listed below:

Medication	Purpose	Dosage	Circumstances under which medication must be administered	Route of Administration	Frequency of Administration

_____ _____
Health Care Practitioner Signature Date