Parent's Request and Physician's Authorization for Self-Administration of Asthma and Other Emergency Medication

Student's Name:	School:	
Parents'/Guardian's/Caretaker's name:	Grade:	Date of Birth:
Home Telephone:	Work Telephone:	

Self-administration of medication is permitted in accordance with WS/FC Policy 5141. Both the student's health care provider and parent, guardian or caretaker must complete this form. The student's name must appear on the inhaler or container.

We, the student and parent/guardian/caretaker agree:

1. To keep the inhaler, equipment, Epi-pen with the student at school rather than in the office or the possession of the teacher or other school employee;
2. To use the inhaler, equipment, Epi-pen in a responsible manner and in accordance with my licensed health care provider's orders;
3. To notify the teacher if I am having more difficulty than usual with my health condition;
4. To not allow any other person to use my medicine, inhaler, equipment or Epi-pen as provided by WS/FC Policy 5131.6 on Alcohol and Drug Abuse;
5. To provide to the school backup asthma or other medication that shall be kept at the school in a location to which the student has immediate access in the event of an asthma, anaphylaxis or other life threatening emergency;
6. To demonstrate to the school nurse, or the nurse's designee, the skill level necessary to use the asthma medication and any device that is necessary to administer the medication; and
7. That the WS/FCS and its employees and agents are not liable for an injury arising from the student's possession and self-administration of asthma or other medication or for the loss of the medication or medical equipment to administer the medication by my child while at school or a school activity.

Signature of Parent/Guardian/Caretaker: Date:	Signature of Student: Date:

To be completed by Health Care Practitioner:

Licensed Health Care Provider: (Print or type)	Medication:
Telephone No:	Dosage:
Email:	Time of Administration:

Verification of Health Care Practitioner. I, the undersigned practitioner, verify (as checked):

☐ that the student has asthma or an allergy that could result in an anaphylactic reaction, or both;

☐ that I have prescribed the above medication for use on school property during the school day, at school-sponsored activities, or while in transit to or from school or school-sponsored events;

☐ that the student understands, has been instructed in self-administration of the asthma or other medication listed above, and has demonstrated the skill level necessary to use the asthma or other medication and any device that is necessary to administer the asthma medication; and

☐ that I have written a treatment plan and an emergency protocol for managing the student's asthma or anaphylaxis episodes and for medication use by the student. (Insert instructions below or attach a copy.)

Treatment Plan and Emergency Protocol:

Signature of Health Care Practitioner:	Date:

Verification of School Nurse: The student has demonstrated the skill level necessary to use the asthma medication and any device that is necessary to administer the medication. ☐ Yes ☐ No

Signature of School Nurse:	Date: