

**Garden Valley School District No. 71**

**STUDENTS**

**3510F(1)**

**AUTHORIZATION FOR SELF-ADMINISTERED ASTHMA/EMERGENCY MEDICATION**

STUDENT'S NAME: \_\_\_\_\_ GRADE \_\_\_\_\_ DOB \_\_\_\_\_

PARENT/GUARDIAN NAME: \_\_\_\_\_ TELEPHONE (HOME) \_\_\_\_\_

(WORK) \_\_\_\_\_

I give my permission for my child to self-administer the medication described below. I shall indemnify and hold harmless the district and its employees or agents for legal fees, costs and any potential damages concerning self-administration of this medication arising out of any claims brought by the above named child or anyone else.

\_\_\_\_\_  
Parent/Guardian's Signature

\_\_\_\_\_  
Date

**THE FOLLOWING IS TO BE COMPLETED BY THE PHYSICIAN:**

I am recommending that the above named student be allowed to self-administer the following medication.

Name and purpose of medication: \_\_\_\_\_

Identification of chronic medical problem: \_\_\_\_\_

\_\_\_\_\_

Prescribed dosage to be taken: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Length of time medication must be taken: \_\_\_\_\_

Possible side effects and/or special precautions to be taken: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Conditions under which self-medication will take place:

\_\_\_\_\_ Independently    *Child must have had training and be proficient in self-administering medication.*

Trainer's Name: \_\_\_\_\_ Date of training: \_\_\_\_\_

\_\_\_\_\_ Under the supervision of a school nurse

Medication should be \_\_\_\_\_ Stored in the health office

\_\_\_\_\_ In the possession of the student

\_\_\_\_\_  
Type or print physician's name

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

Policy History:

Adopted on: 12-13-2011

Reviewed on: 05-01-2017

Revised on: