ASTHMA
MEDICATION/INHALER PERMISSION FORM

Name: _____ Date: _____

CONTACT INFORMATION

MOTHER: _____
Home Tel.# _____
Work Tel.# _____
Cell # _____

FATHER: _____
Home Tel. # _____
Work Tel. # _____
Cell # _____

PHYSICIAN: _____
Office # _____
Cell # _____

MEDICATIONS

The student may take the following medications during school hours:

☐ Check here if student may carry and self-administer these medications.

NAME OF MEDICATION: _____
DOSAGE: _____

WHEN STUDENT SHOULD TAKE THE MEDICATION:
_____

NAME OF MEDICATION: _____

DOSAGE: _____

WHEN STUDENT SHOULD TAKE THE MEDICATION:
_____

FIRST AID

The following are specific instructions to be followed should the student have an asthma attack:

_____
_____

PREVENTION

The following allergens or irritants are particularly bothersome to the student:

_____
_____

SYMPTOMS

The following are symptoms that may indicate the onset of an asthma attack:

_____
_____

PARENTAL PERMISSION & RESPONSIBILITIES

I, Parent/Legal Guardian of the above-named student, understand and agree to the conditions of the school policy and the action plan. I permit the school to seek emergency medical treatment for the student when deemed necessary and appropriate.

If student may administer medication:

☐ I give authorization for self-administration and possession of asthma medication by my child while in school, at school-sponsored activities, while under supervision of school personnel and while in before-school and after-school care on school-operated property. My child demonstrates a full understanding of the proper use of his/her asthma medication.
I take sole responsibility for:

- Monitoring the asthma medication, medication use, and refilling of prescriptions for asthma medication;
- Ensuring the student always carries his/her asthma medication on his/her person;
- Deciding if backup medication will be kept at the school, and providing the school with the backup medication;
- Informing school staff in writing of any changes in the student's treatment or asthma management or changed medical information; and
- Informing school staff in writing of any medication side effects that the school should notify me about if they occur.

I release the School District and its employees and agents of any legal responsibility related to my child's possession and self-administration of his/her asthma medication.
PARENT SIGNATURE: _____
Date: _____

STUDENT AGREEMENT

I, _____ understand and agree to the terms of the asthma action plan.
If student is self-administering medication:

☐ I have been instructed in the proper use of my prescription asthma medication and fully understand how and when to use this medication. I will always carry my medication with me and will not allow another student to use my medication under any circumstances.
STUDENT SIGNATURE: _____
Date: _____

PHYSICIAN APPROVAL

I agree with the above asthma action plan, including the name, purpose, dosage, and administration directions of the asthma medication.

If student is self-administering medication:

☐ It is my professional opinion that the student should be permitted to carry and self-administer his/her asthma medication. The above-named student has been instructed in, and demonstrates an understanding of, the proper use of his/her asthma medication.
PHYSICIAN SIGNATURE _____
Date: _____
Name: _____
Address: _____
_____