# Grandview R-2 School District

**11470 HIGHWAY C**
**HILLSBORO, MISSOURI 63050**

## *AUTHORIZATION FOR ASTHMA CARE AT SCHOOL*

Student Name: _____ Grade _____ Age _____

Medications that have been prescribed for use at school may be administered by a school nurse or authorized staff member if:

- The medication has been appropriately labeled by a pharmacist under the direction of a licensed health care provider.
- The parent or legal guardian has granted permission below for the specific medication to be administered at school

***Please note that medications that have been duly prescribed for **self-administration** by a school-age minor child require completion of an "Asthma Medication Self-Administration Form" as set forth by the Missouri Safe Schools Act of 1996.

**Medication Name** _____ Dose _____ Time/Interval_____

Route/inhalation device _____ Instructions _____

_____

**Medication Name** _____ Dose _____ Time/Interval_____

Route/inhalation device _____ Instructions _____

_____

**Allergies: list known allergies to medications, food, or air-borne substances** _____

_____

*Has the child been hospitalized for asthma-related problems in the last three years? _____ If so, when?

_____

*Has this child required urgent or emergency care due to asthma in the last three years? _____ If so, when?

_____

*Has the child been instructed to take a medication daily to control asthma? _____ If so, when?

_____

I, the parent or legal guardian of the student listed above, give permission for administration of the above listed medications. I also grant permission for exchange of information with the health care provider to facilitate my child's asthma and allergy care.

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

**Signature of parent/legal guardian** _____ **Date** _____

**PLEASE SEE BACK FOR SELF-ADMINISTRATION FORM**

# Grandview R-2 School District

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**HILLSBORO, MISSOURI 63050**
**Phone 636-944-3390**

## *ASTHMA MEDICATION SELF-ADMINISTRATION FORM*

Student Name: _____

The Missouri Safe Schools Act of 1996 provides for students to carry and self-administer lifesaving medications when the following criteria are met:

- Written authorization by the parent/guardian
- Medical history of students' asthma on file at the school
- Written asthma action plan/individual healthcare plan on file at school (info will be on health form)
- Written authorization from the prescribing health care provider that child has asthma, has been trained in the use of the medication and is capable of self-administration of the medication.

MEDICATION NAME _____ Dose _____ Time or Interval _____

Route/Inhalation device _____ Instructions _____

_____

MEDICATION NAME _____ Dose _____ Time or Interval _____

Route/Inhalation device _____ Instructions _____

_____

I, the parent or legal guardian of the student listed above, give permission for this child to **carry and self-administer** the above listed medications. I have instructed my child to notify the school staff if one dose fails to relieve asthma symptoms for 3 or more hours. I understand that, absent any negligence, the school shall incur no liability as a result of any injury arising from the **self-administration of medication** by my child.

**Signature of parent /legal guardian** _____ Date _____

I, a licensed health care provider, certify that this child has a medical history of asthma, has been trained in the use of the listed medication, and is judged to be capable of carrying and self-administering the listed medication(s). The child should notify school staff if one dose of the medication fails to relieve asthma symptoms for at least 3 hours. This child understands the hazards of sharing medications with others and has agreed to refrain from this practice.

**Signature of Health Care Provider** _____ Date _____

Healthcare Provider: Name: _____

Fax: _____ Phone: _____