SELF-ADMINISTER MEDICATION PERMISSION FORM

(Auto-injectable Epinephrine and/or rapid-acting bronchial inhalers ONLY)

Student:____

Physician Statement:

This letter confirms that the above named student is a current patient being treated for:
____

***I agree that the student is responsible and capable of self-administration of the following medications at school (please check all that apply):

_____ Raid-acting bronchial inhaler

- Name of medication:______________ Dose:_________ Frequency:_______________

_____ Auto-injectable Epinephrine

- Name of medication:______________ Dose:_________ Frequency:________________

Healthcare Provider Signature:_______________________________________
Date:____________________________________

Parent Statement:

I the parent/guardian agree that my child is responsible and capable of self-administration of the above medication(s). I release the Choctaw County School District and its employees and agents from liability for any injury arising from the student's self-administration of prescription asthma and/or anaphylaxis medication while on school property or at a school-related event or activity.

Parent/Guardian Signature:_______________________________________
Date:_______________________________________