SELF –ADMINISTRATION OF ASTHMA MEDICATION FORM

Pursuant to the School Code, the Sandoval School District will permit self-administration of medication by a student with asthma. Complete this form if you have a son/daughter that has been diagnosed with asthma.

PARENT/GUARDIAN AGREEMENT FOR STUDENT TO CARRY ASTHMA MEDICATIONS AT SANDOVAL SCHOOL DISTRICT SCHOOLS

I, _____, being the parent/guardian of _____ authorize the Sandoval School District to permit the above named student to self-administer his/her own asthma medication. I will notify the school of changes in medication or my child's condition.

Parent/Guardian Signature: _____ Date: _____

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PHYSICIAN REQUEST FOR SELF-ADMINISTRATION OF ASTHMA MEDICATIONS

Student Name: _____ Birthdate: _____

The above named pupil has _____
(Name of Disease or Syndrome)

I am requesting that the above named student take the following medication(s) during school hours:

_____ _____

_____ _____
Name of Medication(s) (Tablet, Liquid, Capsule, Inhaler)

_____ _____

_____ _____
Dosage Dosage Time(s)

Possible Side Effects: _____

I certify that _____ has been instructed in the use and self-administration

of _____ (name of medication).

He/she understands the need for the medication, and the necessity to report to school personnel any unusual side effects. He/she is capable of using this medication independently. I may be reached at the following phone number in the event of a reaction to the medication or an emergency:

_____ _____
Phone Number of Physician Signature of Physician Date

_____ _____
Address of Physician Print Name of Physician Date