

# ASTHMA MEDICATION SELF-ADMINISTRATION FORM

Student Name: \_\_\_\_\_ B/D \_\_\_\_\_ Student ID \_\_\_\_\_

*The Missouri Safe Schools Act of 1996 and statute 167.627 provide for students to carry and self-administer life-saving medications when the following criteria are met:*

- 1) *Written authorization by the parent/guardian*
- 2) *Medical history of students asthma on file at the school*
- 3) *Written asthma action plan/individual healthcare plan on file at school*
- 4) *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 \_\_\_\_\_

**ALLERGIES: list known allergies to medications, foods, or air-borne substances** \_\_\_\_\_

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 or legal guardian** \_\_\_\_\_ **Date** \_\_\_\_\_

**Parent/Guardian:**

Name: \_\_\_\_\_ Home phone: \_\_\_\_\_

Address: \_\_\_\_\_ Work phone: \_\_\_\_\_

Name: \_\_\_\_\_ Home phone: \_\_\_\_\_

Address: \_\_\_\_\_ Work phone: \_\_\_\_\_

**Emergency Contact:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

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. The 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: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_