STUDENT SELF-ADMINISTRATION OF ASTHMA MEDICATION AUTHORIZATION

CLEAR CREEK INDEPENDENT SCHOOL DISTRICT
CLEAR BROOK HIGH SCHOOL

A student with asthma is entitled to possess and self-administer prescription asthma medicine while on school property or at a school related event or activity if **all** the following conditions are met:

(1) the prescription asthma medicine has been prescribed for the student as indicated by the prescription label on the medicine (the prescription label must be affixed to the inhaler canister);
(2) the self-administration is done in compliance with the prescription or written instructions from the student's physician or other licensed health care provider;
(3) A parent of the student provides the school a written authorization (below), signed by the parent, for the student to self-administer prescription asthma medicine; and
(4) A parent of the student provides the school a written statement from the student's physician or other licensed health care provider, signed by the physician or provider stating the information as indicated on this form.

PHYSICIAN'S AUTHORIZATION FOR SELF-ADMINISTRATION OF ASTHMA MEDICATION

Student's Name: ________________________ Grade: __________ Age: ________

Medication: ____________________________ Diagnosis: ____________________

Prescribed Dosage: ____

Time or Circumstances to Administer Medication: ___________________________

Period for which the medicine is prescribed:___________________________

Contraindication for administration: ___________________________

This student has been diagnosed with asthma and is capable of self-administering the prescription asthma medication. I hereby request that this student be allowed to carry and self-administer the above medicine.

______________________________ ______________________
(Physician's Signature) **(Telephone Number)**

______________________________ ______________________
(Print Physician's Name) **(Date)**

PARENT OR GUARDIAN'S PERMISSION

I hereby give my permission for my child (named above) to carry and self-administer the asthma medication (named above) while on school property or at a school related event or activity. I understand that such use is not monitored by school personnel and that any misuse or abuse of the medication will result in revocation of this permit.

______________________________ ______________________ ______________
(Signature of Parent/Guardian) **(Daytime Telephone Number)** **(Date)**

______________________________ ______________________ ______________
(Emergency Contact Person) **(Daytime Telephone Number)** **(Relationship)**