_____- School
REGARDING ASTHMA INHALERS AND/OR EPIPENS ONLY

Physician: _____

_____ (DOB _____) has _____.

Medication (s) _____ Dosage _____

Circumstances under which the medication is to be taken by the student:
_____
_____

I affirm that the student: 1.) is capable of, and has been instructed by me in, the proper method of self-administration of the emergency medication. 2.) Has been advised of possible side-effects of the medication. 3.) Has been informed of when and how to access emergency services.
This student can possess and self-administer emergency medication at school, on school grounds, at school-sponsored activities, on school- provided transportation, and during school-related programs.

Physician's signature _____Date _____

In my opinion I DO NOT believe it's in this student's best interest to carry and self-administer emergency medications.

Physician's signature _____ Date _____

Parent/Guardian:

I hereby give my permission for the above named Physician to release information to the _____ School concerning medication (s) prescribed for _____
I also give my permission for the above named student to take the medication as prescribed.

I release the school and its employees and agents, including volunteers, from liability as a result of any injury arising from my child's self-administration of the emergency medication, except when the conduct of the school, school employee, or agent would constitute gross negligence, recklessness or intentional misconduct.

Parent/Guardian's signature _____Date _____

Home # _____ Work # _____ Pager/cell # _____