

Campbell County School District #1

Request for Student Self-Administration of Asthma Medications

Student Name: _____	Date of Birth: _____
TO BE COMPLETED BY PHYSICIAN	
Diagnosis _____	
Medication (dosage, frequency, route) _____	
Adverse reactions/Side effects _____ _____	
List other medications currently being taken _____	
Student is capable of self-administration of his/her asthma medication(s) and should be allowed to carry it for this purpose: <input type="checkbox"/> YES <input type="checkbox"/> NO	
Name of Prescribing Physician _____	
Address _____ Phone _____	
Physician's Signature _____ Date _____	

My child has been instructed in the proper use of the above asthma medication(s). I certify that my child is capable of carrying and self administration of medication(s). I request that he/she be permitted to carry and self-administer the above asthma medication(s). I authorize the release of information between the school and physician pertinent to my child's medication(s) and asthma diagnosis.

My child and I understand that there are serious consequences for sharing any medications with others. Furthermore, I understand that the school shall incur no liability, and I will hold the school and its employees harmless against any claims relating to self-administration of asthma medication(s).

Parent/Guardian Name (print) Relationship to Student

Parent/Guardian Signature Date

*This form is good for one school year only and needs to be resubmitted each year.