MOSCOW SCHOOL DISTRICT 281

AUTHORIZATION FOR SELF-ADMINISTERED ASTHMA OR OTHER POTENTIALLY LIFE-THREATENING RESPIRATORY ILLNESS MEDICATION

(Policy 5151.06)

Student's Name _____ Grade _____ DOB _____

Address _____

Parent/Guardian Name _____

Phone (Home) _____ Phone (Work) _____ Cell Phone _____

Emergency Contact if Parent/Guardian Not Available_____ _____
Name Phone

I give my permission for my child to self-administer the medication described below. I shall indemnify and hold harmless the District and its employees or agents for legal fees, costs, and any potential damages concerning self-administration of this medication arising out of any claims brought by the above named child or anyone else.

_____ _____
Parent/Guardian's Signature Date of Signature

THE FOLLOWING IS TO BE COMPLETED BY THE PHYSICIAN:

I am recommending that the above named student be allowed to self-administer the following medication:

Name and purpose of inhaler medication _____

Identification of chronic medical problem _____

Prescribed dosage to be taken _____

Length of time medication must be taken (dates) _____

Conditions under which self-medication will take place: ____ Independently ____ Under the supervision of school nurse

Possible side effects and/or special precautions to be taken _____

_____

Known allergies and triggers _____

Actions to be taken in the event of an emergency, including if the medication does not improve the child's breathing _____

_____

Adverse reactions that should be reported to a physician _____

Any severe adverse reactions that may occur to another child, for whom the inhaler is not prescribed, should such a child receive a dose of the medication _____

Child must have had training and be proficient in self-administering medication.

Trainer's Name _____ Date of Training _____

_____ _____ _____
Physician's Signature Type or Print Physician's Name Emergency Telephone Number

(8-24-04)