ASTHMA MEDICATION SELF-ADMINISTRATION FORM

Student Name: _____ Birthdate: _____ Student ID: _____

The Missouri Safe Schools Act of 1996 and statute 167.627 provides 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:_____ _____Instructions:_____

_____

MEDICATION NAME:_____ Dose:_____ Time or Interval:_____

Route:_____ _____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: _____