

Salmon School District No. 291

STUDENTS

3510F(2)

AUTHORIZATION FOR SELF-ADMINISTERED ASTHMA/EMERGENCY MEDICATION

STUDENT'S
NAME: _____ GRADE _____ DOB _____
PARENT/GUARDIAN NAME: _____ TELEPHONE (HOME) _____
(WORK) _____

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

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 medication _____
Identification of chronic medical problem _____

Prescribed dosage to be taken _____
Length of time medication must be taken _____
Possible side effects and/or special precautions to be taken _____

Conditions under which self-medication will take place:
Independently *Child must have had training and be proficient in self-administering medication.*
Trainer's Name: _____ Date of training: _____

Under the supervision of a school nurse
Medication should be _____ Stored in the health office
_____ In the possession of the student

Type or print physician's name Physician's Signature

Date