Student Self-Administration Medication Permission Form

Student Information *(to be completed by the parent/guardian)*:

Student's Name _____ Date of Birth _____

Grade _____School _____

Parent/Guardian's Name _____

I am the legal guardian of the above student and authorize my child to self-carry and/or administer his/her prescription medication for asthma and/or anaphylaxis while on school property or at a school-related event or activity.

I release the school district and its employees and agents from liability for an injury arising from the student's self-administration of prescription medication while on school property or at a school-related event or activity unless in cases of wanton or willful misconduct.

Parent/Guardian's Signature_____ Date _____

Medical Information *(to be completed by the medical provider)*:

Medication	Dose	When to use	Purpose

I am the medical provider for the above student and feel that he/she is capable of self-carrying and self-administering the above prescription medication and the student knows when and how to use the medication(s). I confirm that he/she has been diagnosed with
_____*Asthma and/or* _____*Anaphylaxis.*

Medical Provider's Signature _____ Date _____

Date Authorization is Valid _____ to _____

Adopted: 2-15-17