Cache Public Schools

SELF ADMINISTERED ASTHMA MEDICATION AUTHORIZATION FORM

This form must be completed by the parent/guardian and the student's physician prior to permitting the student to possess and use a prescribed inhaler at all times during the school day.

Student Name _____School_____

Grade_____DOB_____Address_____

Parent # 1 Name_____Parent # 2 Name_____

Home Phone_____Cell Phone_____Work Phone_____

Physician's Name _____ Phone Number_____

As per State Law 70 O.S. 1-116.3 "*Medication* " means a metered dose or dry powder inhaler to alleviate asthmatic symptoms prescribed by a physician and having an individual label and "*Self -Administration* " means a student's use of medication pursuant to prescription or written direction from a physician.

TO BE COMPLETED BY THE PARENT/GUARDIAN

I authorize my child to self-administer his/her inhaled asthma medication. I understand my child will be permitted to possess and use the prescribed inhaler at all times. In compliance with the provisions of Section 1-116.3 of Title 70 of the Oklahoma Statutes, I agree:

1. To provide the school with an **EMERGENCY SUPPLY** of the student's medication.
2. The school district and its employees and agents shall incur no liability as a result of any injury arising from the self-administration of medication by the student.

I agree to the above statements regarding self administration of asthma medications. I, the undersigned parent/guardian, request that a designated school employee administer to my child the following medication if my child is unable to give his/her medication on their own. I understand my child is not allowed to share his/her asthma medication while at school.

Medication Name _____ Dosage_____mg

Frequency: Inhaler _____ puffs every _____ hours as needed
Nebulizer ____ vials every _____ hours as needed

Length of time to be given ☐ Entire school year ☐ Specific time period _____

Parent Name (please print)_____Date_____

Parent Signature _____ Health Form #3

TO BE COMPLETED BY THE PHYSICIAN

Student's Name_____

Diagnosis for which Medication is given: ☐ Asthma ☐ Other _____

Medication Name: _____ (Inhaler)Dosage: _____mg

Medication Name: _____ (Nebulizer) Dosage: _____mg

Frequency:

- ❑ Inhaler_____ puffs every _____ hours as needed
- ❑ Nebulizer _____ vial every _____ hours as needed

Repeat if not improved in _____ minutes.

If needed, medication should be given _____ minutes prior to exercise. (P.E., Recess, Sports)

Relevant side effects: ☐ None expected ☐ Specify _____

Length of time to be given: ☐ Entire school year ☐ Specific time period_____

Other information: _____

_____

_____

I agree this student has asthma and is capable of and has been instructed in the proper method of self-administration of his/her asthma medication.

*** **Required** ***

Physician Signature: _____

Physician Name/Title: _____ (Please print or type)

Date: _____

Telephone: _____ Fax: _____

Address: _____