BEEVILLE
INDEPENDENT SCHOOL DISTRICT
INSPIRING BOLD INNOVATIVE LEADERS

Parent Request and Physician Authorization for Student Self-Administration of Asthma or Anaphylaxis Medication while in School or School-Related Events or Activities

Texas Education Code Chapter 38 Section 38.0151 specifies that a student with asthma or anaphylaxis is entitled to possess and self-administer prescription asthma or anaphylaxis medicine while on school property or at a school-related event or activity if:

1. The prescription medicine has been prescribed for that student as indicated by the prescription label on the medicine;
2. The student has demonstrated to the student's physician or other licensed health care provider and the school nurse, if available, the skill level necessary to self-administer the prescription medication, including the use of any device required to administer the medication;
3. The self-administration is done in compliance with the prescription or written instructions from the student's physician or other licensed health care provider; and
4. A parent of the student provides to the school:
   a. A written authorization, signed by the parent, for the student to self-administer the prescription medicine while on school property or at a school–related event or activity; and
   b. A written statement from the student's physician or other licensed health care provider, signed by the physician or provider, that states:
      i. The student has asthma or anaphylaxis and is capable of self-administering the prescription medicine;
      ii. The name and purpose of the medicine;
      iii. The prescribed dosage for the medicine;
      iv. The times at which or circumstances under which the medicine may be administered; and
      v. The period for which the medicine is prescribed.

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① PHYSICIAN AUTHORIZATION for self-carry, and self-administration of:
(check one) _____ASTHMA; _____ANAPHYLAXIS medication.

As the physician, or provider, I certify that my patient _____
Patient Name
_____ **has a diagnosis of (circle one) ASTHMA ANAPHYLAXIS OTHER:** _____,
DOB
which requires the use of the following emergency medication:

•NAME OF MEDICATION _____
•PRESCRIBED DOSAGE OF THE MEDICATION
_____
•ROUTE AND INSTRUCTIONS FOR MEDICATION ADMINISTRATION
_____
•TIME OR CIRCUMSTANCE UNDER WHICH MEDICATION MAY BE SELF-ADMINISTERED:
_____
•MEDICATION IS PRESCRIBED FROM TIME PERIOD _____ TO _____.

My patient has been instructed in the proper use of the above medication. It is my professional opinion that he/she understands the appropriate use of this medication and should be allowed to carry and self-administer this medication while on school property, or at a school related event or activity.

EMERGENCY ACTION PLAN Attached? _____ Yes _____ No

_____ _____ _____
Physicians/Medical Provider Signature **Office Number** **Date**

Student Name/ID Number	Campus	DOB	Grade	Room #

②Parent Acknowledgment and Authorization for Student to self-carry and self-administer the Emergency Medication as prescribed by physician (read, complete, and sign):

I agree with the recommendations of my child's physician as noted above and have informed my child that he/she may carry and self-administer his/her prescription emergency medication (check one):

_____rescue inhaler ____ Epinephrine Auto Injector

while on school property or school related events or activities. I understand that the medication container must show an appropriate and complete pharmacy prescription label.

_____	_____	_____
Parent/Guardian Signature	Contact Number	Date

③STUDENT ACKNOWLEDGEMENT: EXPECTATIONS AND RESPONSIBILITIES: PRESCRIBED MEDICATION KEPT ON PERSON

I, _____,

STUDENT NAME

will not share any medications with anyone. This medication will remain with me always. I will use the medication, only for myself, the way the doctor showed me. If the rescue inhaler medication does not help me, and I do not feel better after 20 minutes, or I start to have symptoms again within 3 hours since last using my inhaler, I will ask to be taken to the nurse office, or have my parent/guardian called immediately. If I use my epinephrine auto injector, I know that 911 emergency services will need to be called so that I can be taken and seen at the nearest hospital.

Student Printed Name_____ Student Signature_____

Parent Printed Name_____ Parent Signature_____

SCHOOL USE:

Student Demonstrates proper use of medication with school nurse? _____Yes _____No

Parent Contact Information: _____

_____

Student's Family doctor: _____ Office Number: _____

Specialist Doctor Name: _____ Phone Number. _____

Last Hospital Visit date and Name of Hospital: _____

Staff Member Name and Signature: _____ Title: _____ Date: _____

Student Name/ID Number	DOB	Room #