Lake Pend Oreille School District #84

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3510F-1

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 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