FORT WORTH INDEPENDENT SCHOOL DISTRICT
Health Services Department

Self-Administration of Prescribed Asthma or Anaphylaxis Medicine by Student

This form is to be completed by the parent and physician/licensed health care provider of students who are to keep prescribed asthma or anaphylaxis medication on their person and self-administer it as prescribed.

School name: _____ School Year: _____

Parent Request

We, the undersigned parents of _____ request that our child be allowed to keep the prescribed asthma or anaphylaxis medication and his/her person at all times and self-administer it as requested by the physician.

We understand that it is the student's sole responsibility to keep the prescription medication on his/her possession. If they are misplaced or used by other students, this privilege will be revoked.

I give permission for the school nurse to consult with the above named student's physician/licensed prescriber regarding any questions that arise with regard to the listed medication(s) or medical condition(s) being treated by the medication(s).

_____ _____
Signature of Parent(s) Date

Physician Request

You are hereby authorized to allow _____ to carry the prescription medicine on his/her possession at all times.

_____ _____
Name of Medication Dosage and Time of Administration

Please check all that is applicable.

☐ Student is knowledgeable about this medication, and how to administer it.

☐ Student has the skills to safely possess and use the prescribed medication.

☐ Student may self-administer the medication.

All authorizations expire at the end of the school year.

_____ _____
Signature of Physician/Licensed Health Care Provider Telephone Number

_____ _____
Printed Name of Physician/Licensed Health Care Provider Date

The student has demonstrated the skill level necessary to self-administer the prescription medication including the use of any device required to administer the medication.

_____ _____
Signature of School Nurse Date