

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 on his/her possession at all times.

to carry the prescription medicine

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