**Denison Independent School District**

**School Health Services**

**Authorization for Self-Administration of Asthma or Anaphylaxis Medication**

**(*To be completed at the beginning of each school year and kept on file with the campus nurse)***

Name of student\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade\_\_\_\_\_\_\_\_ Teacher/Homeroom \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Condition for which medication is being administered \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| *To Be Completed by Physician* |

[ ]  I have instructed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ in the proper way to use his/her medications. It is my professional opinion that he/she **should** be allowed to carry and self-administer his/her medication, as prescribed on the Emergency Action Plan, while on school property or at school-related events. His/her parents are aware that there will not be medication available in the school clinic unless they decide to provide extra medication.

[ ]  It is my professional opinion that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **should not** be allowed to carry and self-administer any of his/her medications while on school property or at school related events. It should be kept in a designated area and be accessible to the student.

Physician/Practitioner \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

 Printed Name Signature Date

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| *To Be Completed by Parent* |

I permit my child to carry his/her medication as prescribed on the Emergency Action Plan. I understand that my child, not the school, is responsible for the storage, possession and use of the medication. I understand that sharing medication with other students will result in disciplinary action.

Describe how your child will carry/store their medication(s):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Parent/Guardian Signature Date Phone Number

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| *To Be Completed by Student* |

I understand the purpose and appropriate use of my medication. I understand that I, not the school, am responsible for the storage, possession and use of the medication. I understand that sharing medication with other students is potentially dangerous and will result in disciplinary action.

Student Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_