SCHULENBURG ISD
SCHOOL HEALTH SERVICES

Possession and Self-Administration of Prescription Asthma and Anaphylaxis Medication

Student_____ Grade Level_____

TO BE COMPLETED BY THE PHYSICIAN

Diagnosis_____

	Name/Purpose of Medication	Dose	Time/Frequency	Duration
1)	_____	_____	_____	_____
2)	_____	_____	_____	_____

Please explain any restriction and/or emergency measures to be followed:_____

_____

_____

Start date_____ to (discontinue date) _____

In signing this form I am certifying that in my professional opinion, this student has adequate knowledge of their health condition and above named medications. I am aware that school personnel are available at all times to administer medications. I have discussed with the student and parent the risks/dangers of overmedication and in my opinion the student and parent have adequate understanding of the condition to safely and responsibly self-administer the above named medications as prescribed.

_____ _____
Physician Signature Printed Physician Name

_____ _____
Office phone number Office fax number

TO BE COMPLETED BY THE PARENT/GUARDIAN

It is necessary that my student be allowed to possess and self-administer the prescribed medication(s) listed above,

_____ _____
Parent/Guardian Signature Date

_____ _____
Home phone number Other phone number

Please have pharmacist place label directly on medication and not on box.

This form must be renewed annually and must be filed in the nurse office for student to carry medication.

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