

**AUTHORIZATION FOR SELF ADMINISTRATION OF INHALED ASTHMA MEDICATION**

**PHYSICIAN'S ORDER:**

Date \_\_\_\_\_

Name of Student \_\_\_\_\_ Grade \_\_\_\_\_ Date of Birth \_\_\_\_\_

Student's Address \_\_\_\_\_ Home Phone: \_\_\_\_\_

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

Name of Drug \_\_\_\_\_ Dose & Frequency \_\_\_\_\_

Length of time during which medication shall be administered:

School Year \_\_\_\_\_/\_\_\_\_\_ or From \_\_\_\_\_ To \_\_\_\_\_  
Date Date

Relevant side effects & management of \_\_\_\_\_

**SELF ADMINISTRATION:**

1. I have conferred with this child's parents and feel that this medication may be self-administered.
2. This student has been appropriately instructed regarding self-administration.

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone

**PERMISSION OF PARENT OR GUARDIAN FOR SELF ADMINISTRATION OF MEDICATION**

To: \_\_\_\_\_ Date \_\_\_\_\_

I hereby request that the above medication ordered by

\_\_\_\_\_  
Name of Physician

for \_\_\_\_\_ be self-administered by my child.

Name of Student

I assume responsibility for granting permission for my child to self-administer medication as approved and instructed by the physician.

I understand it would benefit my child for the school nurse to be supplied with back-up medication in the event the medication is lost or misplaced.

I give consent for communication between the nurse and the prescriber to ensure safe administration of the medication.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Telephone

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