



AUTHORIZATION FOR SELF-ADMINISTRATION OF ASTHMA/ALLERGY MEDICATION

STUDENT NAME: _____ **Birthdate:** _____ **Grade:** _____

STUDENT ALLERGIES: _____

NAME OF PARENT: _____

HOME #: _____ **WORK #:** _____ **CELL #:** _____

PRESCRIBING HEALTH CARE PROVIDER _____

OFFICE #: _____ **FAX #:** _____

DESCRIPTION OF CONDITION | REASON FOR MEDICATION: _____

PRESCRIBED MEDICATION & STRENGTH: _____

DOSAGE: _____ **ROUTE:** _____

POSSIBLE ADVERSE REACTION(S): _____

SPECIAL INSTRUCTIONS: _____

_____ (student's name) has ____ asthma ____ allergies that are potentially life-threatening and is treated with prescription medication that must be carried by the student. He/She is capable of administering their own medication at school and at school-related or school-sponsored activities. Salem Lutheran School will be informed of any changes to the medication specified on this form, to the dosage, or to the recommended regimen by an updated version of this consent form. The student understand that the intentional misuse of any medication or medical equipment that could knowingly and recklessly cause harm to another student will result in disciplinary action. It is recommended to have a duplicate medication in the School Nurse's Office.

I hereby acknowledge that I have read and accept the Salem Lutheran School medication policy and will update the School Nurse in writing with any changes to my child's allergies or health information. An up-to-date medication policy, containing the latest information can be found in the Family Handbook.

PARENT | GUARDIAN SIGNATURE: _____ **DATE:** _____

HEALTH CARE PROVIDER SIGNATURE: _____ **DATE:** _____

STUDENT SIGNATURE: _____ **DATE:** _____

Please return this form to the school nurse and/or bring with medication.