Date received by school_____

Albany County School District #1

REQUEST FOR STUDENT SELF-ADMINISTRATION OF INHALED ASTHMA MEDICATION(S)

Child's Name_____ **School**_____

Date of Birth_____ **Grade**_____

TO BE COMPLETED BY PHYSICIAN:

*Diagnosis*_____

*RX (Dosage/Frequency/Route)*_____

*Adverse Reactions/Side Effects*_____

_____

*List other Medications Currently Being Taken*_____

_____

Student is capable of appropriate and accurate self-administration of his/her asthma medication(s), and should be allowed to carry it for this purpose. ☐ *YES* ☐ *NO*

*Name of Prescribing Physician*_____

*Address*_____ *Phone*_____

*Physician's Signature*_____ *Date*_____

My child has been instructed in the proper use of the above asthma medication(s). I certify that my child is capable of self-administration. I request that he/she be permitted to carry and self-administer the above asthma medication(s). I authorize the release of information between the school and physician pertinent to my child's medication(s) and asthma diagnosis.

My child and I understand that there are serious consequences for sharing any medications with others. Furthermore, I understand that the school shall incur no liability, and I will hold the school and its employees harmless against any claims relating to self-administration of asthma medications. I realize that my child may be required to demonstrate that s/he can properly use the medication (inhaler) before being allowed to possess and self-administer the medication.

I will ensure that the medication carried by my child with always be current and of the proper dosage. I further will ensure that my child will have accessible to him/her the medication at all times while s/he is in the school setting.

_____ _____

Parent/Guardian Name (please print) *Relationship to Student*

_____ _____

Parent/Guardian Signature *Date*