REAVIS HIGH SCHOOL 2016-2017
SELF-ADMINISTRATION OF ASTHMA MEDICATION

ASTHMA MEDICATION CANNOT BE SELF ADMINISTERED AT SCHOOL WITHOUT A WRITTEN REQUEST FROM THE PARENT OR GUARDIAN.

______________________________________	____________________________	____________________
Student's Name	**Student's I.D. #**	**Date**

Name of medication: _______________________ **Dosage:**_______________ **Route:**____________ **Time:** _______________

Expected discontinuation date: _______________ Condition and purpose for prescribed medication: ______________________

The medication (inhaler) <u>must</u> be in the original labeled container as dispensed by the pharmacy or physician. The label must contain the student's name, name of medication, date, dosage, and directions in which the medication is to be taken.

I hereby request and grant permission for my

Son/Daughter ____according to ____

Name of Student **Physician's Name**

to carry his/her inhaler and assume responsibility for its administration. I further waive any claims against the school district, its employees and agents arising out of the self-administration of said medication. I agree to hold harmless and indemnify the school district, its employees and agents, either jointly or severally, from and against any and all liability, claims, demands, damages or causes of action or injuries, costs and expenses, including attorneys' fees, resulting from or arising out of the self-administration of medication.

I further authorize the release and exchange of information between Reavis High School and the physician regarding above listed medications.

________________________________	_____________________	______________________	_______________
Parent Signature	**Home Phone Number**	**Emergency Phone**	**Date**

_________________________________	_________________________________	_______________________
Printed Name of Physician	**Physician Address**	**Physician Phone Number**