REAVIS HIGH SCHOOL 2018-2019
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) must 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**