

**PARENT/PHYSICIAN AUTHORIZATION FOR SELF-ADMINISTRATION OF ASTHMA  
OR ANAPHYLAXIS MEDICATION BY A STUDENT**

**STUDENT NAME:** \_\_\_\_\_ **D.O.B.** \_\_\_\_\_

**PARENT AUTHORIZATION:**

I have reviewed the attached guidelines and procedures for Self-Administration of Prescription Asthma or Anaphylaxis Medication by Students; discussed them with my child; and request that my child be able to possess and self-administer his/her prescription asthma or anaphylaxis medication while on school property or at a school-related event or activity. I understand that the asthma or anaphylaxis medication must be prescribed for my child as indicated on the prescription label, which must be affixed to the medication container (inhaler canister or packaging box).

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**PHYSICIAN AUTHORIZATION:**

The medical history and my examination of \_\_\_\_\_,  
(Student's Full Name)

indicates that he/she does have asthma or anaphylaxis. The student has been educated and is knowledgeable about his/her asthma or anaphylaxis and can properly self-administer the prescribed medication and determine its effectiveness.

Name of Medication: \_\_\_\_\_

Purpose of Medication: \_\_\_\_\_

Prescribed Dosage: \_\_\_\_\_

Times at which or circumstances under which the medicine may be administered:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Period of time for which the medicine has been prescribed: Long term (chronic condition) Short term and should be discontinued by \_\_\_\_\_ (Date)

Physician's Printed Name: \_\_\_\_\_

Physician's Office Address AND Office Phone: \_\_\_\_\_  
\_\_\_\_\_

**Physician's Signature:** \_\_\_\_\_