TOMBALL INDEPENDENT SCHOOL DISTRICT

AUTHORIZATION FOR SELF-ADMINISTRATION OF ASTHMA/ALLERGY MEDICATION

Name of student ____Grade __________

Name of parent ____

Home # ___________________ Work # __________________ Cell # _____________

Prescribing health care provider ____

Office # __________________________ Fax # ________________________________

Description of condition/reason for medication ________________________________

Prescribed medication and strength ____

Administration: Dosage __________ Method ___________ Time(s) ________________

Anticipated length of treatment ____

Possible adverse reaction(s) ____

____ (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. The District 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 understands 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.

Parent ____ Date _________________

Health care provider _________________________________ Date _________________

Student ____Date _________________