Documentation
Self-Administration of Asthma Medication

***Reference**: Board Policy FFAC*

Student Name:_____Date of Birth:_____Grade: ___ Teacher: _____

Parent Name:_____ Best phone number/s: _____

Emergency Contact/Relationship: _____/_____ Phone number/s: _____

To be completed by Physician Licensed by the State of Texas

Doctor's Printed Name: _____ Address: _____Phone: _____

The student listed above has been seen in my office and has asthma and/or anaphylaxis and is treated with medication (name, dosage, and condition listed below).

Condition/diagnosis requiring medication/s: _____

Name of medication/s:_____ Dosage: _____

Medication at school should be used in the following manner: _____

Starting date: _____ Ending date: _____

☐ I have instructed the student names above in the proper way to use his/her medication. It is my professional opinion that this student should be allowed to carry and self-administer the emergency rescue medication while on school property or attending a school-related function/event. The student should be allowed to administer his/her medication at school and any school-related or sponsored activities. Any changes to this specific medication or the regimen for administration of the medication will be updated with a new form provided by the parent to the school.

Physician's Signature: _____ Date: _____

To be completed by the parent

☐ *I understand my signature below indicates permission for the campus principal/nurse/designee to allow my child to possess and administer his/her medication listed in the protocol above while on school property or at any school-related or sponsored activities. I confirm that any misuse of my child's medication will result in it being stored in the Nurse's office. I also understand that if the doctor makes any changes, I must provide a new Self-Administration form to the school as soon as possible.*

Parent Signature: _____ Date: _____

Nurses Notes/Documentation

☐ Student knows the name, correct dosage, purpose, expected effects, and medication side effects.

☐ Student demonstrates correct use/administration of medication.

☐ Student understands that medication must have a prescription label affixed and authorization must be carried.

☐ Student understands allowing anyone else to use this medication will result in disciplinary action and violating any of this agreement can rescind the privilege of carrying this medication.

Student Signature: _____ Nurse Signature: _____ Date:_____

Retention: Date of authorization + 2 years
Date of Destruction: _____

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