

Asthma Medication Permission Form

Student's Name _____ Date of Birth _____ Age _____
School _____ Grade _____ Teacher _____
Address/City/Zip _____
Mother/Guardian Name _____ Work/Cell Number _____
Address/City/Zip _____ Home Number _____
Father /Guardian Name _____ Work/Cell Number _____
Address/City/Zip and phone number, if different from above _____

TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED PRESCRIBER

Physician's Name _____
Address _____
Phone Number _____ Emergency Number _____
Medication _____
Symptoms when this medication is to be given _____
Dose _____
Frequency _____
Maximum # of doses @ school _____
Peak flow readings _____
Beginning date _____ Ending date _____

Permission for the Self-Administration and Carrying the Asthma Medication by the Student

This child is capable of self-administration of this medication while on school property or school-related events or activities. This means the prescription medication may be used at the student's discretion. Yes___No___

The student may carry the medication. Yes___ No___

Physician Signature _____ Date _____

Parent/Guardian

I realize that the school does not have to agree to allow medication to be given to a student by school personnel. I understand that the school's agreeing to allow the medication to be given is for my benefit and the student's benefit. Such agreement by the school is adequate consideration of my agreements contained herein. In consideration for the school agreeing to allow the medication to be given to the student as requested herein, I agree to indemnify and hold harmless the Archdiocese of Galveston – Houston, its servants, agents, and employees including, but not limited to the parish, the school, the principal, and the individuals giving the medication of and from any and all claims, demands, or causes of action arising out of or in any way connected with the giving of the medication or failing to give the medication to the student. Further, for said consideration, I, on behalf of myself and the other parent of the student, hereby release and waive any and all claims, demands, or causes of action against the Archdiocese of Galveston – Houston, its agents, servants, or employees, including, but not limited to the parish, the school, the principal, and the individual giving or failing to give the medication.

Parent/Guardian Signature _____ Date _____

Reference: Asthma and Allergy Foundation of American, 1233 20th St, NW Suite 402, Washington, DC 20036 * www.aafa.org* 1-800-ASTHMA

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