

ASTHMA SELF-ADMINISTRATION FORM

Today's Date _____

Student Name _____

Birth Date _____

Address _____

City _____

State _____

Zip _____

EMERGENCY CONTACT INFORMATION:

Name _____ Phone: _____

HEALTH CARE PROVIDER AUTHORIZATION

The above-named student is under my care. I feel it is medically appropriate for the student to self-administer asthma medication and be in possession of asthma medication at all times. The medication prescribed for this student is:

Name of Medication _____

Type of Medication (inhaler, tablet, etc) _____

Dosage _____

Possible Side affects _____

Signature of Health Care Provider _____

Date _____

PARENT/GUARDIAN AUTHORIZATION

I authorize my child to carry and self-administer the medications described above consistent with Utah Code 53A-11-602.

I do not authorize my child to carry and self-administer this medication. Please keep my child's medication with appropriate school personnel.

My child and I understand there are serious consequences, which may include suspension, for sharing any medications with others.

Parent/Guardian Signature _____

Date _____