ASTHMA SELF-ADMINISTRATION FORM

Save Print

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_____
Dosage_____
Possible Side Affects_____
_____

_____

Signature of Health Care Provider Date

PARENT/GUARDIAN AUTHORIZATION

❑ I authorize my child to carry and self-administer the medication described above consistent with Utah Code § 53A-11-602.
❑ I do no 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