DISTRICT 95 HEALTH SERVICES ASTHMA FORM

PERMIT FOR ADMINISTRATION OF <u>REQUIRED</u> ASTHMA MEDICATION(S) DURING SCHOOL HOURS

CHILD'S NAME_____ BIRTHDATE_____

_____

(FOLLOWING TO BE COMPLETED BY PHYSICIAN) Date_____

This child _____is under my medical care for_____

(Diagnosis)

_____and medication is **required** during the school day for the purpose of _____

Name of Drug	Dosage	Frequency	Time to be Given At School	Duration	Side Effects

- ☐ Student may self-administer this medication
- ☐ Student must carry medication on his/her person

APPROVED:

SIGNATURE OF PHYSICIAN _____

PRINTED NAME OF PHYSICIAN_____

_____

School Nurse

ADDRESS_____

EMERGENCY TELEPHONE # _____

_____

(TO BE COMPLETED BY PARENT OR LEGAL GUARDIAN)

I give permission for my child to receive the above medication(s) as directed by the physician. The medication will be sent to school in a container appropriately labeled by the pharmacy. I will notify the school in writing if the medication is discontinued. Also, I will obtain a written doctor's order if the medication dosage is changed. I will bring the medication to the school nurse. I understand that it is the responsibility of the student to report to the office at the scheduled time to receive the medication. I further completely release and excuse District 95 and its employees and agents of any liability or obligation of any nature in any way related to the District's medication policy and procedure.

DATE:_____ PARENT'S SIGNATURE_____

ADDRESS_____

_____

CITY STATE ZIP CODE

TELEPHONE_____/_____

HOME BUSINESS