Moberly School District
Health Services FY2011 School Year

ASTHMA MEDICATION SELF-ADMINISTRATION FORM

Student Name: ____**Grade:** _________**Date of Birth**________________

The Missouri Safe Schools Act of 1996 provides for students to carry and self-administer life-saving medications when the following criteria are met:

1) *Written authorization by the parent/guardian*
2) *Medical history of students asthma on file at the school*
3) *Written asthma action plan/individual healthcare plan on file at school*
4) *Written authorization from the prescribing physician that child has asthma, has been trained in the use of the medication and is capable of self-administration of the medication.*

MEDICATION NAME ____________________________________ Dose _______________ Time or Interval _______________

Route/Inhalation device ____Instructions _________________________________

____

MEDICATION NAME ____________________________________ Dose _______________ Time or Interval _______________

Route/Inhalation device ____Instructions _________________________________

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ALLERGIES: list known allergies to medications, foods, or air-borne substances _____________________________________

I, the parent or legal guardian of the student listed above, give permission for this child to carry and self-administer the above listed medications. I have instructed my child to notify the school staff if one dose fails to relieve asthma symptoms for 3 or more hours.

Signature of parent or legal guardian ____ **Date** _________________

Parent/Guardian:
Name: ____ Phone:______________________

Emergency Contact:
Name: ____ Phone: ___________________________

I certify that this child has a medical history of asthma, has been trained in the use of the listed medication, and is judged to be capable of carrying and self-administering the listed medication(s). The child should notify school staff if one dose of the medication fails to relieve asthma symptoms for at least 3 hours.

Signature of Physician ____ **Date** _________________

Physician:
Name: ____

Fax: ____ Phone: ____

Address: ____City: ___________________________Zip: _________