**Authorization for Self-Administration of Asthma and/or Anaphylaxis Medication**

Student Name: Click or tap here to enter text. Date of Birth: Click or tap here to enter text.

Campus: Click or tap here to enter text. Grade: Choose an item.

*Please print:*

Parent/Guardian: Work Phone:

Address: Mobile Phone:

 Home Phone:

**Prescribing Physician or Health Care Provider Recommendation**

Provider Name (print): Phone:

This student, *(name)*, has the following health condition(s):

 [ ]  Asthma [ ]  Anaphylaxis in responseto:

He/she has been instructed in proper use of his/her prescribed medication indicated in the table below.

In my opinion, he/she is capable of administering his/her own prescription medication at school and at school-related or school-sponsored activities.

List prescription asthma and/or anaphylaxis medication(s) that may be self-administered by the student:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medication Name** | **Dose** | **Route** | **Frequency** | **Reason** (asthma or anaphylaxis) |
|  |  |  |  |  |
|  |  |  |  |  |

Thisauthorization is valid through: (date).

Signature of MD/DO/NP/PA Date Signed

**Parent/Guardian Authorization:**

I authorize my child, , to self-administer emergency prescription medication as recommended by his/her health care provider (above).

I understand my child’s medication must have a prescription label indicating his/her name.

If my child is unable to self-administer the medication(s) listed above, I give permission for trained school employees to administer emergency medication in accordance with the prescription label.

I understand that an updated version of this form is required when any changes are made to the medication(s) specified on this form, including dosage.

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Printed Name & Signature of Parent/Guardian Completing the Form Date

**School Nurse Assessment:**

In accordance with Texas Education Code 38.015(b)(2), has demonstrated to the school nurse the skill level necessary to self-administer the listed medication(s).

*If applicable*, he/she has been instructed to notify the school nurse, teacher, coach, athletic trainer, or other nearby district employee following self-administration of an emergency epinephrine auto-injector.

This form is on file in the student’s Health Record.

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Printed Name & Signature of School Nurse Date