

Millwood Public Schools 6724 Martin L. King Oklahoma City, OK 73111	Adopted: 6/28/04 Revised: 8/4/08	Policy J-11-R1
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**Physician's Authorization for Self-Administration of  
Asthma Medication At School**

Name of Student: \_\_\_\_\_ Birthdate: \_\_\_\_\_

School: \_\_\_\_\_ School Year: \_\_\_\_\_ Grade: \_\_\_\_\_

Medical Condition	Medication	Strength	Dose	Time	Route	Possible Side Effect

Other Considerations/Directions: \_\_\_\_\_

Start Date: \_\_\_\_\_ Stop Date: \_\_\_\_\_

(All authorizations expire at the end of the school year)

Asthma Medication

- Student is knowledgeable about the asthma medication and proper method to administer it.
- Student may self-administer the asthma medication; student has been trained on self-administration, purpose of medication, symptoms requiring use of medication, and possible adverse reactions or side effects of both regular and over dosage.

Anaphylaxis Medication

- Student is knowledgeable about the anaphylaxis medication and proper method to administer it.
- Student may self-administer the anaphylaxis medication; student has been trained on self-administration of anaphylaxis medication, including but not limited to Epenephrine injectors; student has been instructed on purpose of anaphylaxis medication, symptoms requiring use of anaphylaxis medication, and possible adverse reactions or side effects of regular dosage or over dosage.

\_\_\_\_\_  
Print or Type Name of Physician Prescriber

\_\_\_\_\_  
Physician's/Licensed Prescriber's Signature

\_\_\_\_\_  
Clinic Address

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Date

**Parent/Guardian Authorization**

1. I request that the above medication(s) be given during school hours as ordered by this student's physician/licensed prescriber. I also request the medication (s) be given on field trips, as prescribed.
  2. I release school personnel from liability in the event adverse reactions result from taking the medication(s).
  3. I will notify the school of any change in the medication(s), (ex. Dosage change, medication is discontinued etc).
  4. I give permission for the school nurse to communicate with the student's teachers about the student's health condition(s) and the action of the medication(s).
  5. I give permission for the school nurse to consult with the above named student's physician/licensed prescriber regarding any questions that arise with regard to the listed medication(s) or medical condition(s) being treated by the medication(s).
  6. I give permission for the medication(s) to be given by designated personnel as delegated by the school nurse.
- As recommended and stated above by my child's physician, my son/daughter may self-administer his/her medication.  
(Not applicable for controlled substances, such as Ritalin, Dexedrine, Codeine, etc.)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Relationship to Student

**NOTE: Medication is to be supplied in the original/prescription bottle.**