**Written Authorization for Self-Administration of Asthma Medication**

**By Minor Children at School (Renew Form Each School Year) Rev 3/2019**

Student Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_School/Grade\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, parent/legal guardian of the above named student hereby request authorization for possession and self-administration of asthma medication by this student while at school, at school sponsored activities, while under supervision of school personnel, and while in before or after school care on school operated property.

**I understand that**:

▪ the school district and its employees shall incur no liability for any injury to the student caused by; a.) The self administration of his/her asthma medication except for injury caused by willful or wanton misconduct; b.) The student’s use, misuse, overuse, neglected use, or failed use of hi/her asthma medication; & c.) lost, misplaced, outdated, inaccessible, empty, or faulty asthma medication and/or devices.

▪ the school may choose to require supervision of the medication administration in the event that the student does not demonstrate appropriate use or proper technique with asthma medications.

▪ the school has the authority to enforce rules and consequences for inappropriate behavior demonstrated by the student in association with the possession and/or use of asthma medications and that the school has the authority to require supervision of medication use as deemed appropriate for the safety of all students and staff.

**I take sole responsibility for**:

▪ The monitoring of asthma medication, proper use of medication, and refills of medication. The school will not be responsible for recording, supervising, or monitoring the use of asthma medication. I will ensure that student carries medication on his/her person and deciding if a backup inhaler will be provided to the school clinic.

▪ Informing the school in writing of any changes in treatment, of any exacerbations, hospitalizations, and/or new or changed student information, and of any side effects that warrant communication with parent/guardian, & coordinate distribution of the student’s asthma management plan to school staff. (Teacher, nurse, PE teachers, before or after school staff).

**I understand & agree to the conditions of the school district policy. I permit the school to seek emergency care for the student if deemed necessary and appropriate. I accept legal responsibility should the medication be misused or given or taken by a person other that the above named student. I release the Paulding County School District , its agents, and its employees from any legal responsibility related to the above named student’s possession and administration of his/her asthma medication.**

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Parent/Guardian Signature Date

**I have been instructed in the proper use of my asthma medication and fully understand when and how to use this medication. I will always carry my medication with me and will not allow another student to use my medication under any circumstance. I agree to the terms of the school policy.**

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Student Signature Date

**The above named student demonstrates understanding and proper use of his/her asthma medications. It is my professional opinion that they be permitted to carry and self – administer his/her asthma medication. I have provided the parent with a written asthma management/emergency plan including name, purpose, dosage, and administration directions.**

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Physician’s Signature Date