LAMAR CONSOLIDATED INDEPENDENT SCHOOL DISTRICT
HEALTH SERVICES

**PARENT/PHYSICIAN AUTHORIZATION FOR SELF-ADMINISTRATION OF ASTHMA OR ANAPHYLAXIS MEDICATION BY A STUDENT**

**STUDENT NAME: _____ D.O.B. _____**

**PARENT AUTHORIZATION:**

I have reviewed the attached guidelines and procedures for Self-Administration of Prescription Asthma or Anaphylaxis Medication by Students; discussed them with my child; and request that my child be able to possess and self-administer his/her prescription asthma or anaphylaxis medication while on school property or at a school-related event or activity. I understand that the asthma or anaphylaxis medication must be prescribed for my child as indicated on the prescription label, which must be affixed to the medication container (inhaler canister or packaging box).

**Parent/Guardian Signature**:_____ **Date:** _____

**PHYSICIAN AUTHORIZATION:**

The medical history and my examination of _____,
(Student's Full Name)
indicates that he/she does have asthma or anaphylaxis. The student has been educated and is knowledgeable about his/her asthma or anaphylaxis and can properly self-administer the prescribed medication and determine its effectiveness.

Name of Medication: _____

Purpose of Medication: _____

Prescribed Dosage: _____

Times at which or circumstances under which the medicine may be administered:
_____
_____
_____

Period of time for which the medicine has been prescribed: Long term (chronic condition) Short term and should be discontinued by _____ (Date)

Physician's Printed Name: _____

Physician's Office Address AND Office Phone: _____

_____

**Physician's Signature**:_____