

ACADEMY INDEPENDENT SCHOOL DISTRICT

Consent for Self-Administration of Inhaler at School

Student: _____ Date: _____ Grade: _____

Physician's Statement

Type and Purpose of Inhaler: _____

Time and Indications for Usage: _____

The above named student has asthma and is capable of possessing and self-administering this prescription asthma medication as prescribed at school.

Signature of Healthcare Provider

Date

Parental/Guardian Consent

The above named student has my permission to possess and self-administer the asthma medication as prescribed at school.

Signature of Parent/Guardian

Date

SCHOOL OFFICE USE

Filed in the school office on _____ by _____