Northern Highlands Regional High School

AUTHORIZATION FOR SELF-ADMINISTRATION FOR
ASTHMA OR POTENTIALLY LIFE-THREATENING ILLNESS

To be completed by the parent (please print or type):

Student's Name____ ________________
Last *First* *Date of Birth*

______________________ ______________________ ________________
Physician's Name *Address* *Phone #*

I request that the above named student, as authorized by the physician below, be permitted to self-administer the medicines indicated below. Only enough medication for that school day is to be carried by the student, which is to be pre-measured and labeled. The privilege of self-administration of medication may be revoked if the pupil fails to comply with school policy or this agreement or endangers himself/herself or others. I understand and agree in making this request that neither Northern Highlands or its staff shall incur any liability as a result of any injury/reaction arising from the self-medication. This permission is effective for the current school year.

__________ ______________________ ____________ ____________
Date *Parent/Guardian Signature* *Home Phone* *Emergency Phone*

The following must be completed by the *Physician*:

Diagnosis of asthma or potentially life-threatening illness (specify)__________________________

Medication____

Form____Dose__________________________

If given daily, what time?____

If PRN____

Describe indications____

How soon may it be repeated____

List significant side effects____

Length of time this treatment is prescribed__________________________________

Is child capable of self-administration of medication__________________________

Has the child been instructed on the proper use of the medication________________

Must the medication be administered during the school day______________________

Other information____

Date________________________ Physician's Signature______________________________
Physician's Stamp

Date________________________ School Physician________________________________