

# 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 themselves 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 \_\_\_\_\_