

West Hartford Public Schools

28 South Main Street, West Hartford, Connecticut 06107

Phone: 860-523-3500

Authorization for Self Administration of Inhaled Asthma Medication **Secondary Schools Only**

To the Parent/Guardian: Students receiving or taking **any** medication at school must have a written order from a Doctor, Dentist, APRN or PA licensed to practice in Connecticut or any other state, as well as parental permission on file in the office of the School Nurse. If the Nurse does not know what medications a student may be taking, she/he cannot function effectively in the event of an emergency situation. The prescriber and parent/guardian may authorize self-administration of asthma medication. Medication must remain in the container in which it was purchased.

I have read and understand the above statement and assume responsibility for granting permission for my child to self-administer medication as approved and instructed below.

I understand it would benefit my child for the School Nurse to be supplied with back-up medication in the event the medication is lost or misplaced.

Parent/Guardian Signature _____ Date _____

Address _____ Phone # _____

To the Physician: Please fill out the following section.

Student name _____ Date of Birth _____

Condition for Prescribing _____

Medication name _____ Dose _____ Route _____

Time of Administration/Frequency _____

Medication administered from Start Date _____ Finish Date _____

Relevant side effects _____

Allergies _____ Special instructions _____

1. I have conferred with this child's parents and feel that this medication may be self-administered.
2. This student has been appropriately instructed regarding self-administration.

Prescriber's Name/Title _____ Phone # _____

Address _____

Prescriber's Signature _____ Date _____

Self admim med doc 02/02