Katy Independent School District
HEALTH SERVICES DEPARTMENT

# Parent/Physician Authorization for Self-Administration of Asthma or Anaphylaxis Medication by a Student

| Student's Name: Last | First | Middle | Grade Level |
|---|---|---|---|
| | | | |

## 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 medication while on school property or at a school-related event or activity. I understand that the 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). I release the school district and employees of any liability arising from self-administration.

Type of Medication:

❑ Prescription Asthma Medication ❑ Anaphylaxis Medication

| Parent Signature | Date |
|---|---|
| | |

## Physician Authorization

The medical history and my examination of the above-named student indicates that he/she does have a medical condition. The student has been educated and is knowledgeable about his/her medical condition and can properly self-administer the prescribed medication and determine its effectiveness.

Medical Condition:

❑ Asthma ❑ Anaphylaxis

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

| Printed Name of Physician | Office Phone Number |
|---|---|
| | |

| Physician's Signature | Date |
|---|---|
| | |