

**Shoshone Joint School District No. 312**

**STUDENTS**

**3510F(1)**

**AUTHORIZATION FOR SELF-ADMINISTERED ASTHMA/EMERGENCY MEDICATION**

STUDENT'S  
NAME: \_\_\_\_\_ GRADE \_\_\_\_\_ DOB \_\_\_\_\_  
PARENT/GUARDIAN NAME: \_\_\_\_\_ TELEPHONE (HOME) \_\_\_\_\_  
(WORK) \_\_\_\_\_

I give my permission for my child to self-administer the medication described below. I shall indemnify and hold harmless the district and its employees or agents for legal fees, costs and any potential damages concerning self-administration of this medication arising out of any claims brought by the above named child or anyone else.

\_\_\_\_\_  
Parent/Guardian's Signature Date

**THE FOLLOWING IS TO BE COMPLETED BY THE PHYSICIAN:**

I am recommending that the above named student be allowed to self-administer the following medication.

Name and purpose of medication \_\_\_\_\_  
Identification of chronic medical problem \_\_\_\_\_

\_\_\_\_\_  
Prescribed dosage to be taken \_\_\_\_\_  
Length of time medication must be taken \_\_\_\_\_  
Possible side effects and/or special precautions to be taken \_\_\_\_\_  
Possible side effects and/or special precautions to be taken \_\_\_\_\_

\_\_\_\_\_  
Conditions under which self-medication will take place:  
\_\_\_\_\_ Independently *Child must have had training and be proficient in self-administering medication.*  
Trainer's Name: \_\_\_\_\_ Date of training: \_\_\_\_\_

\_\_\_\_\_ Under the supervision of a school nurse  
Medication should be \_\_\_\_\_ Stored in the health office  
\_\_\_\_\_ In the possession of the student

\_\_\_\_\_  
Type or print physician's name Physician's Signature

\_\_\_\_\_  
Date