JOINT SCHOOL DISTRICT NO. 2
1303 E. CENTRAL DR. MERIDIAN, IDAHO. PHONE (208) 855-4500

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 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:

Medical condition: _____

Name of medication: _____

Medication dosage: _____

Possible side effects and/or special precautions to be taken: _____

_____

Actions to take in case of emergency: _____

_____

_____

This child may carry and self administer the above medication, and is trained and proficient in self-administration.

Trainer's Name: _____ Date of training: _____

This authorization is in effect for one year from date of signature.

_____ _____
Physician Date

_____
Type or print physician's name