CIRCLEVILLE CITY SCHOOLS
REQUEST FOR STUDENTS TO CARRY AND ADMINISTER THEIR OWN INHALED MEDICATION

NAME_____ **PHONE**_____

ADDRESS_____

BIRTHDATE_____ **SCHOOL**_____ **GRADE/ROOM**_____

Physician's Section

_____ is under my care and should be allowed to carry and administer
Student Name
his/her personal asthma inhaler medication _____.
Medication Name

_____
Dosage, Frequency, and Time of Administration

The student has been instructed and has demonstrated knowledge to the parent and/or physician of the proper circumstances in which this medication should be administered, as well as its proper storage and care.

Possible side effects or severe adverse reactions to observe in the student are:_____
_____

Procedures to follow in the event that the medication does not produce the expected relief from the student's asthma attack:_____
_____

_____

Prescription start date_____ Prescription ending date_____

Date form completed_____ Physician's Signature_____

Physician printed name_____ Phone_____

Parent/Guardian Section

I request and give permission for my child to administer his/her asthma inhaler medication in keeping with the **Physician's Section** above. Further, I release and agree to hold the Board of Education, its officials, and its employees, harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization. I further agree to submit a revised statement signed by the physician who has prescribed the medication described in the **Physician's Section** above, in the event that I become aware that any of the information has changed. I have read and understand the policy of Circleville City Schools for the administration of medication and affirm that this request entails special circumstances justifying an exception from the usual administration of medication by school personnel.

Signature of Parent/Guardian_____ Date_____

Printed Name of Parent/Guardian_____ Phone_____

Work Phone_____ Cell Phone_____ Pager_____