Saint Mary
OF THE IMMACULATE CONCEPTION SCHOOL

SCHOOL HEALTH SERVICES 2017-2018 SCHOOL YEAR
SELF-MEDICATION FOR ASTHMA INHALERS AUTHORIZATION FORM

Name of Student: _____ **Date of Birth:** _____

Student Address: _____ **Grade:** _____

City & ZipCode: _____ **Phone:** _____

Name of Medication: _____

Dosage: _____ **Frequency:** _____

Beginning Date of Request: _____ **Expiration Date of this Request:** _____

Reaction(s) and/or possible side-effects to be reported to physician: _____

_____

Specific instructions for Administration: _____

_____

Physician and Parent/Guardian Name and Emergency Phone Numbers

It is not possible for the above specified medication to be taken at home under the supervision of a parent and it is, therefore, necessary that the specified medication be administered during school hours. The medication provided shall be in the original container obtained by the parent/guardian from the pharmacist. This medication can be safely administered by non-medical personnel.

In consideration of my child being administered the above specified medication at my request, on behalf of my child, my spouse, and myself, I hereby assume all risks in connection therewith, and I further release the Diocese of Cleveland, the Bishop of the Roman Catholic Diocese of Cleveland, Saint Mary of the Immaculate Conception School, Saint Mary of the Immaculate Conception Parish, all employees and volunteers from all claims, judgments, liability for any injury or damage due to the designated administration of said medication to my son/daughter.

Physician's Name: _____ **Phone:** _____

Physician's Signature: _____ **Date:** _____

Parent/Guardian's Name: _____ **Phone:** _____

Parent/Guardian's Signature: _____ **Cell:** _____

Date: _____

Copies must be on file in the School Office and/or Nurse's files.