## AUTHORIZATION FOR SELF-ADMINISTRATION OF MEDICATION FOR ASTHMA/ALLERGIES K-12 AND INSULIN FOR GRADES 6-12

## PART A

## Parent/Legal Guardian to Complete

Name of Student:		Date of Birth:	Grade/Teac	Grade/Teacher:	
The above student has been him/her to administer at schofurnish this medication. I acadministration of medication against any claims relating to I also acknowledge, in according to the school of the	ool as ordered the mecknowledge that the so a and agree to indemn to the self-administration dance with the Nurse	dication(s) listed below. I use thool incurs no liability for ify and hold the school, and ion of such medication.  Practice Act, the need and	understand that it is any injury resulting d its employees and give permission for	my responsibility to from the self- agents, harmless appropriate	
communication between the question to enable the nurse prescription/treatment itself, medication/treatment, and of treatment.	to administer safe and implementation of the	d effective care. This include prescription/treatment in	des communication school, student resp	concerning the onse to the	
Parent/Legal Guardian Signature		Parent/Legal Guardian (Printed Name) Today's Date			
	Phys	PART B sician to Complete			
Current Diagnosis(es):					
Medication	Purpose	Dosage	Time/Fi	requency	
Conditions & Special Circ	cumstances for use:				
This student is authorized medication. He/she has the					
Physician Signature Pl		Physician (Printed Name)		ny's Date	
Physician Phone Number	<del></del>				
	Part C: S	chool Nurse to Compl	ete		
School Nurse Review of o	order and procedure	with student. Complete	d satisfactorily: _		
				Date of Review	