SELF-ADMINISTRATION CONSENT FORM

Name of Student________________________________ Date of Birth__________

Address____ Grade_______

Emergency Phone Number___________________________

Physicians Statement

1. Name and type of medication:____________________________________
2. Is prescribed medication for an asthmatic condition? YES/NO
3. Dosage/amount to be given:______________________________________
4. Route of administration:____
5. Frequency and time of administration:_____________________________
6. Duration (week, month, end of current year)_________________________
7. Diagnosis, intended effect, and anticipated reaction to medicine (symptoms, side effects, etc.):_____________________________________
8. Other medication(s) student is taking:_______________________________
9. Other requirements or special circumstances:________________________
10. Must this medication be administered during the school day in order to allow the student to attend school or participate in school activities? YES/NO
11. Is supervised student self-administration authorized? YES/NO
12. **FOR ASTHMA MEDICATION ONLY * IS SELF-ADMINISTRATION AUTHORIZED?** YES/NO

Pursuant to Oklahoma law, upon parental consent, a student prescribed asthma medication may possess and use his/her asthma medication during school or at school sponsored activities without the supervision of District personnel.

The student has demonstrated and understands appropriate use of asthma medication: YES/NO

Physician signature and printed name_______________________________

Physician's address____

Phone Number____