BERMUDIAN SPRINGS SCHOOL DISTRICT
York Springs, Pennsylvania 17372-0501

MEDICATION PERMISSION FORM FOR SELF-ADMINISTRATION OF ASTHMA INHALERS

Physician's Order

Student Name_____

Name of Medication: _____

Dosage: _____

Time/Frequency: _____

Reason for Medication: _____

Possible Side Effect: _____

Recommendations: _____

Estimated Termination Date: _____

(All authorizations expire at the end of the school year.)

Please check all that applies:

☐ Student is knowledgeable about this medication and how to administer it and understands not to share the inhaler with another person.

☐ Student may self-administer medications as prescribed by his/her physician and may carry his/her inhaler with them while on school property.

Physician's Signature_____ Date_____

Address_____

Phone Number: _____

As the parent/guardian of above named student, I relieve the school district and its employees of any responsibility for the benefits or consequences of the above listed medication when it is physician-prescribed and parent/guardian authorized. I further acknowledge that the school bears no responsibility for ensuring that the medication is taken. I am aware that any improper use/sharing of the above named medication will result in the immediate confiscation of the inhaler and loss of privilege to self-administer if the medication policy is violated.

- My child may self-administer the above medication as prescribed by his/her physician.
- My child will report to the school nurse or designated personnel immediately following each use of the inhaler. The nurse may assess and monitor student use to assure that safe practices are being followed.

Parent's/Guardian's Signature _____ Date _____

I agree to be solely responsible for my asthma inhaler and to follow the directions for its use as ordered by my physician, as well at the district's medication policy. I am aware that any abuse of the privilege will result in the confiscation of my inhaler.

Student's Signature_____ Date_____