Robbinsdale Area School District 281

AUTHORIZATION TO SELF-ADMINISTER ASTHMA MEDICATION

Students Name_____DOB_____Grade_____

To Be Completed By Prescribing Health Professional

It is my professional opinion that this student is capable of carrying and self-administering the following medication:

Medication	Dose	Route	Frequency
Medication	Dose	Route	Frequency

Comments_____

The student is knowledgeable about the medication and has the skills to safely administer it.
The student has received an asthma evaluation and has a management plan.

Health Care Provider Signature _____ Clinic Name _____

Printed Name _____ Phone # _____ Date _____

To Be Completed by Parent/Guardian

I give my permission for my child to self-administer medication at school as prescribed by my child's health professional.

Information regarding my child's asthma may be shared with all appropriate school staff.
I authorize reciprocal release of information related to my child's health/medications between the school nurse and the prescribing health professional/clinic.
I will inform the health office of any change in medication and asthma status of my child.
The school is released of liability in the event that adverse reactions results from my child's self-administration of asthma medication.

Signature of Parent/Guardian _____ Date _____

Daytime Phone Number(s) _____

Upon receipt of this authorization, the school nurse is required by state law to assess the student's knowledge and skills to safely possess and use an inhaler at school.