MADISON COUNTY SCHOOLS

School Year

AUTHORIZATION FOR STUDENT TO CARRY AND SELF-ADMINISTER PRESCRIPTION ASTHMA AND/OR ANAPHYLAXIS MEDICATION

☞ *Action Plans are required by law for students diagnosed with Asthma and/or Anaphylaxis Conditions* ☜

Student's Name:		Date of Birth:
School:	Grade:	Teacher:

Diagnosis: _____

Medication / Purpose: _____

Prescribed Dose: _____

TIME: (The times at which or circumstances under which medication may be administered): _____

HEALTH CARE PROVIDER STATEMENT

The student has asthma and/or anaphylaxis and is capable of self-administering the prescription asthma and or anaphylaxis medication. I recommend the student be allowed to carry prescription medication as prescribed.

☛ **Provider's Signature/DATE** _____ ☛ **Printed Provider Name** _____

Telephone: _____ Fax: _____

********** PARENT/GUARDIAN SECTION**********

PARENT/GUARDIAN AUTHORIZATION

I authorize my child/student to carry and self-administer prescription asthma and/or anaphylaxis medication while on school property or at a school-related event or activity unless in cases of wanton or willful misconduct.

The parent/guardian releases the school district and its employees and agents from liability for an injury arising from the student's self-administration or staff assistance in administration of prescription asthma and/or anaphylaxis medication while on school property or at a school related event or activity unless in cases of wanton or willful misconduct.

☛ **Parent/Guardian Signature/DATE** _____ ☛ **Printed Name** _____

Emergency contact phone number: _____