AUBURN-WASHBURN SCHOOLS
EMERGENCY ASTHMA/ALLERGY MEDICATIONS

PART A: *Parent/Legal Guardian to Complete* – for students K-12

Name of Student: ______________________________ Date of Birth: ________________

School: ____ Grade: ____________

The above student has been instructed on self-administration of medication, and I hereby give my permission for him/her to administer at school as ordered the medication(s) listed below. I understand that it is my responsibility to furnish this medication. I acknowledge that the school incurs no liability for any injury resulting from the self-administration of medication and agree to indemnify and hold the school, and its employees and agents, harmless against any claims relating to the self-administration of such medication.

I also acknowledge the need and give permission for appropriate communications between the school health professional and the medical prescriber related to the specific treatment in question, including communication concerning: 1. the prescription or treatment itself (e.g., questions regarding dosage, method of administration, potential drug interactions, size of catheter for emergency insertion in the track of a dislodged gastrostomy tube); 2. implementation of the treatment in school (e.g., questions regarding safety concerns, infection control issues, or modifications in the treatment order related to the school setting or student's academic schedule); 3. student outcomes from the treatment (e.g., questions regarding observed side effects, possible untoward reactions, observations of behavior changes in the classroom); 4. and other pertinent issues related to the student's diagnosis, condition, or treatment.

____________________________ ____________________________ ______________
Parent/Legal Guardian Signature Parent/Legal Guardian Printed Name Today's Date

PART B: *Physician to Complete*

Medication	Purpose	Dosage	Time/Frequency

Conditions & Special Circumstances for use: ________________________________

Length of time medication is to be administered: ____________________________

____________________________ ____________________________ ______________
Physician Signature Physician Printed Name Today's Date

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Physician Phone Number

PART C: *School Nurse to Complete*

School Nurse review of order and procedure with the student completed: ________________
Date of Review

RETURN TO SCHOOL NURSE