FORT WORTH INDEPENDENT SCHOOL DISTRICT
Health Services Department

Self-Administration of Prescribed Asthma or Anaphylaxis Medicine by Student

This form is to be completed by the parent and physician/licensed health care provider of students who are to keep prescribed asthma or anaphylaxis medication on their person and self-administer it as prescribed.

School name: Daggett Montessori School Year: 2024-2025

Parent Request

We, the undersigned parents of ____________________ request that our child be allowed to keep the prescribed asthma or anaphylaxis medication and his/her person at all times and self-administer it as requested by the physician.

We understand that it is the student's sole responsibility to keep the prescription medication on his/her possession. If they are misplaced or used by other students, this privilege will be revoked.

I give permission for the school nurse to consult with the above named student's physician/licensed prescriber regarding any questions that arise with regard to the listed medication(s) or medical condition(s) being treated by the medication(s).

Signature of Parent(s) ____________________ Date ____________________

Physician Request

You are hereby authorized to allow ____________________ to carry the prescription medicine on his/her possession at all times.

Name of Medication ____________________ Dosage and Time of Administration ____________________

Please check all that is applicable.

- ☐ Student is knowledgeable about this medication, and how to administer it.
- ☐ Student has the skills to safely possess and use the prescribed medication.
- ☐ Student may self-administer the medication.

All authorizations expire at the end of the school year.

Signature of Physician/Licensed Health Care Provider ____________________ Telephone Number ____________________

Printed Name of Physician/Licensed Health Care Provider ____________________ Date ____________________

The student has demonstrated the skill level necessary to self-administer the prescription medication including the use of any device required to administer the medication.

Signature of School Nurse ____________________ Date ____________________

DISTRITO ESCOLAR INDEPENDIENTE DE FORT WORTH

Departamento de Servicios de Salud

Auto-administración del estudiante de medicina recetada para asma o anafilaxis

Esta forma la deben de llenar los padresy un médico/proveedor de cuidado de salud del estudiante que usa medicina recetada para asma o anafilaxis y que se la auto-suministra.

Nombre de la escuela: Daggett Montessori Año escolar: 2024-2025

Petición de los padres

Nostros, los que firmamos y que somos padres de ______________________________ Solicitamos que se Les permita a nuestros hijos quedarse con su medicina recetada para asma o anafilaxis y que se la suministren ellow mismos como lo indique el médico.

Entendemos que es responsabilidad del estudiante el que se quede con su medicina. Si la dejan en otro lado o la usa otro estudiante, se le quitará este privilegio.

Doy permiso a la enfermera a que consulte con el médico del estudiante arriba mencionado cualquier pregunta que surja relacionada de las medicinas o condiciones médicas que son tratadas con la medicina.

______________________________ ______________________________

Firma de los padres Fecha

Physician Request

You are hereby authorized to allow ______________________________ to carry the prescription medicine on his/her possession at all times.

______________________________ ______________________________

Name of Medication Dosage and Time of Administration

Please check all that is applicable.

- ☐ Student is knowledgeable about this medication, and how to administer it.
- ☐ Student has the skills to safely possess and use the prescribed medication.
- ☐ Student may self-administer the medication.

All authorizations expire at the end of the school year.

______________________________ ______________________________

Signature of Physician/Licensed Health Care Provider Telephone Number

______________________________ ______________________________

Printed Name of Physician/Licensed Health Care Provider Date

The student has demonstrated the skill level necessary to self-administer the prescription medication including the use of any device required to administer the medication.

______________________________ ______________________________

Signature of School Nurse Date