# ASTHMA MEDICATION SELF-ADMINISTRATION FORM

**Student Name** _____ **DOB**_____ **GRADE** ____**Teacher:** _____

*The Missouri Safe Schools Act of 1996 provides for students to carry and self-administer life-saving asthma medications when the following criteria are met:*

1) *Written authorization by the parent/guardian*
2) *Medical history of student's asthma on file at the school*
3) *Written asthma action plan/individual healthcare plan on file at school*
4) *Written authorization from the prescribing health care provider that child has asthma, has been trained in the use of the medication and is capable of self-administration of the medication*

**MEDICATION NAME** _____ Dose _____ Time or Interval _____

Route/ inhalation device _____ Instructions _____

_____

**MEDICATION NAME** _____ Dose _____ Time or Interval _____

Route/ inhalation device _____ Instructions _____

_____

**ALLERGIES: list known allergies to medications, foods, or air-borne substances** _____

_____

I, the parent or legal guardian of the student listed above, give permission for this child to carry and self-administer the above listed medications. I have instructed my child to notify the school staff if one dose fails to relieve asthma symptoms for 3 or more hours.

**Signature of parent or legal guardian** _____ **Date** _____

**Parent/Guardian:**
Name:_____ Home Phone _____
Address:_____ Work Phone _____
Name_____ Home Phone _____
Address:_____ Work Phone_____

**Emergency Contacts:**
Name:_____ Phone: _____

I, a licensed health care provider, certify that this child has a medical history of asthma, has been trained in the use of the listed medication, and is judged to be capable of carrying and self-administering the listed medication(s). The child should notify school staff if one dose of the medication fails to relieve asthma symptoms for at least 3 hours.

**Signature of health care provider** _____ **Date** _____

**Healthcare Provider:** Name: _____
Fax: _____ Phone: _____
Address: _____ City: _____ Zip: _____