SELF ADMINISTERED MEDICATION FORM

Physician consent for student to carry and self-administer medication / inhaler.

NAME OF STUDENT____ D.O.B.__________________________

I have instructed both parent and child in the administration of the following inhaler(s) / medication(s):
Please include all prescribed medication(s), dosage(s) and frequency.

1. ____
2. ____
3. ____

I judge this child able to carry the inhaler(s) / medications(s) to school and self-medicate in school throughout the day, as needed.

___________________________________ ______________________________

PHYSICIAN NAME (PRINT) PHYSICIAN SIGNATURE

_____________________ ______________________________

DATE OFFICE PHONE #