TRIAD LOCAL SCHOOLS PARENT REQUEST AND AUTHORIZATION FOR THE POSSESSION AND USE OF ASTHMA INHALER / OTHER EMERGENCY MEDICATION(S)

PARENT: THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT TO USE PRESCRIBED MEDICATIONS OR TO RECEIVE TREATMENT IN SCHOOL. ALL SPACES MUST BE COMPLETED.

Name of Student _____ Grade _____

Address: _____
Street Address City State Zip

A. I am requesting permission for my child named above to: (Check all that apply)

- ☐ receive the prescribed medication indicated from the designated school personnel.
- ☐ keep emergency medication in his/her possession.
- ☐ self-administer the prescribed medication in his/her possession.
- ☐ receive prescribed treatment in accordance with the authorized prescription.

B. I will assume responsibility for safe delivery of the medication/drug to school. (The medication /drug must be in the container in which it was dispensed by the prescriber or a licensed pharmacist.

C. I will notify the school immediately if there is any change in the use of the medication/drug or the prescribed treatment. (You must submit to the District a revised licensed prescriber's statement, signed by the prescriber, if any of the information contained in the statement changes.)

D. I release and agree to hold the Triad Board of Education, its officials, and its employees harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.

Signature of Parent _____ Date: _____
Parent, guardian or other person having care or charge of the student:

Home Telephone: _____ Work Telephone: _____

LICENSED PRESCRIBER: TRIAD SCHOOL DISTRICT REQUIRES THAT ALL OF THE FOLLOWING INFORMATION BE PROVIDED BEFORE IT WILL ADMISTER MEDICATION 0R TREATMENT TO THE ABOVE NAMED STUDENT.

Licensed Prescriber's statement: I am a licensed health professional authorized to prescribe drugs, and I have prescribed the following asthma inhaler / other emergency medication to the above named student (specify the name of the drug).

_____

_____

Date the administration of the drug is to begin _____ Date the administration of the drug is to cease _____

Specify the dosage or the drug to be administered, and the times or intervals at which each dosage of the drug is to be administered.

_____

_____

Report the following side effects (i.e., severe adverse reactions) to my office immediately:

_____

_____

Procedure to follow in the event that medication does not produce the expected relief from student's asthma attack or other condition requiring emergency medication:

_____

_____

Prescriber's Signature _____ Office Telephone: _____

Printed/Typed Name _____ Date: _____

Copies must be provided to building principal and to the school nurse.