GOOSE CREEK CONSOLIDATED INDEPENDENT SCHOOL DISTRICT

School Heath Program

Student Self-Administration of Asthma or Anaphylaxis Medications

Student's Name: _____ Date of Birth: _____ School Year: _____

House Bill 1 allows a student with asthma or anaphylaxis to possess and self-administer prescription asthma or anaphylaxis medication while on school property or at a school-related event or activity provided that the school has received written authorization from the student's parents and a statement from the student's physician. The completion of this form will meet these requirements. The physician's statement must be kept on file in the office of the school nurse or principal.

Physician's Statement

Student's Name: _____,is under my care for the treatment of

❑ Asthma ❑ Anaphylaxis

❑ It is in my professional opinion that the above named student should be allowed to carry and self-administer the following prescription asthma or anaphylaxis medication/s while on school property or at a school-related event. I have instructed the above name student in the proper way to use the following medications.

❑ It is in my professional opinion that the above named student should NOT be allowed to carry and self-administer his/her asthma or anaphylaxis medication/s while on school property or at school-related events.

Medication: _____
Purpose: _____
Dosage: _____
When to use: _____
Can be repeated _____ times _____ minutes apart

Medication: _____
Purpose: _____
Dosage: _____
When to use: _____
Can be repeated _____ times _____ minutes apart

These medications are prescribed for the time period_____ until _____

Physician's Signature: _____ Date: _____
Physician's Name: _____ Telephone: _____
Physician's Address: _____

Parent Authorization

I, _____ (parent/guardian), request that Goose Creek CISD permit my child, _____ to carry and self-administer prescription asthma or anaphylaxis medication/s on school property and at school-related events according to the physician's direction. Any changes to the above medication/s, dosage or recommended regimen will be accompanied by an updated version of this consent. I understand the school nurse, the school district or any of its other agents shall not be responsible or liable in any manner for any claim arising, directly or indirectly, for provision of the services requested. **This form is to be completed each school year.**

Parent/Guardian Signature: _____ Date _____

Student Signature (If 18 years of age): _____ Date _____