

Holden Christian Academy

Medication Self-administration Permission Form (For asthma inhalers)

Student's Name _____ Date of Birth _____

Address _____

Parent's Name _____ Emergency Contact Number: _____

Doctor's Name/Number _____

Diagnosis _____

Medication _____

Signs/symptoms for which student would self-administer: _____

Dosage and directions for administration: _____

This student is capable of self-administering this medication and of recognizing when it is needed.

Physician signature _____

My child has permission to self-administer this medication at school when needed. I understand that HCA personnel are not responsible for any problems arising from the administration of this medication. I understand that HCA does not have a school nurse on staff.

Parent/guardian signature _____