ASTHMA MEDICATION AUTHORIZATION

Joseph Badger School District
7119 State Route 7, Kinsman, Ohio 44428 Phone: 330-876-2800 Fax: 330-876-2811

To the Parent:

The following information is necessary for any student to receive prescribed medication for Asthma on school premises. ******* PLEASE COMPLETE ONLY THE SECTION THAT APPLIES*******

Section 1

Please complete this section if your child is to **COME TO THE CLINIC TO USE A RESCUE INHALER:**

Name of student ______________________ Date of birth ________________ Age ____________

School *(BHS 9-12, BMS 5-8, BES K-4)* ______________________ Grade ________________ Teacher *(if applicable)* ____________

1. I am requesting permission for my child named above to receive physician prescribed mediation at school.
2. I will assume responsibility for the safe delivery of the medication to school for the initial and all subsequent doses, for maintaining adequate amounts of medication, and replacing it prior to its expiration date.
3. I will provide the school with a new Medication Authorization form if there is any change in the dosage or use of the medication, and I will notify the school in writing if the medication is discontinued. I understand that verbal notification is permissible followed by written documentation by the next school day. Faxing the appropriate form is also acceptable.
4. I release and agree to hold the Board of Education, and its officials, and its employees harmless from any liability for damages or injury resulting directly or indirectly from this authorization, in accordance with the Medication policy.

Signature of Parent/Guardian ______________________ Relationship to Student ______________________

Home Phone ________________ Work/Cell Phone ________________ Date ________________

SECTION 2

Please complete this section if your child is to **CARRY / USE A RESCUE INHALER AT SCHOOL:**

Name of student ______________________ Date of birth ________________ Age ____________

School *(BHS 9-12, BMS 5-8, BES K-4)* ______________________ Grade ________________ Teacher *(if applicable)* ____________

1. I am requesting permission for my child named above to receive physician prescribed mediation at school.
2. I will assume responsibility for the safe delivery of the medication to school for the initial and all subsequent doses, for maintaining adequate amounts of medication, and replacing it prior to its expiration date.
3. I will assume responsibility of my child reporting the need of the emergency medication to the nearest adult in supervision prior to its use, using the medication appropriately and according to the physician's prescription in the presence of the adult in supervision, and reporting its use to the Board authorized employee after its use.
4. I will provide the school with a new Medication Authorization form if there is any change in the dosage or use of the medication, and I will notify the school in writing if the medication is discontinued. I understand that verbal notification is permissible followed by written documentation by the next school day. Faxing the appropriate form is also acceptable.
5. I release and agree to hold the Board of Education, and its officials, and its employees harmless from any liability for damages or injury resulting directly or indirectly from this authorization, in accordance with the Medication policy.

Signature of Parent/Guardian ______________________ Relationship to Student ______________________

Home Phone ________________ Work/Cell Phone ________________ Date ________________