AVONWORTH SCHOOL DISTRICT

Parental Permission Form for Student Possession and Self-Administration of Asthma Inhalers or Epinepherine Auto-Injectors

Students in the district will be permitted to carry and self-administer asthma inhalers or epinephrine auto injectors during the school day if the following requirements are met:

1. The district Asthma or Allergy Action Plan form is on file in the health office.

2. A written statement from physician, CRNP, PA is provided that includes the following: Name of child, name of medication, amount of medication to be taken, time/circumstance to be taken and any potential serious side effects or emergency response required. It shall include a statement whether the child is qualified and able to self-administer medication. (see reverse)

3. Both parent and student must sign the waiver relieving the school district and its personnel of any responsibility for failure of the student to use the medication properly.

4. The above forms must be updated annually.

5. The Avonworth School District reserves the right to withdraw permission if the student is unable to demonstrate responsible behavior while carrying the medication, or any incidents occur while the student is in possession of this medication at school.

In accordance with Pennsylvania State Law, I hereby agree to allow my child to carry his/her asthma inhaler or epinephrine auto-injector as directed by his/her physician. I acknowledge that the Avonworth School District and its staff bear no responsibility for the benefits or consequences of the medication use, and that the district bears no responsibility for ensuring that the medication is taken correctly. The district reserves the right to withdraw permission at any time if the student is unable to demonstrate responsible behavior in carrying and/or taking this medication or if any incidents involving other students occur.

____________________________________ _______________________________________

Parent Signature **Date** **Student Signature** **Date**

Use the reverse side of this form for the physician's order, statement of qualification and signature

Emergency Medication Administration Consent & Licensed Prescriber Order

Student Name: ____ Date/Time: _____________________

School:____ Teacher/Grade:__________________

<u>Physician / Licensed Prescriber Medication Order:</u>

Patient's name:____**Date:**______________

Name of medication:____

Reason for Administration:____

Route and dosage:____

Time of administration:______________________________ **Discontinuation Date:**_________________

Directions:____

Potential serious side effects or reactions: ____

Emergency Response: ____

Diagnosis/Reason for Medication:____

All other medications this child is taking: ____

In my professional opinion the above child is qualified and able to self-administer the above medication.

Licensed Prescriber signature:____

Licensed Prescriber name printed:____