



**PERMISSION TO POSSESS AND SELF-ADMINISTER ASTHMA OR ANAPHYLAXIS  
MEDICATION DURING SCHOOL HOURS & SCHOOL SPONSORED EVENTS**

Name of student: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Route: \_\_\_\_\_ Time(s): \_\_\_\_\_

If 'as needed' (PRN), indicate when dose can be repeated: \_\_\_\_\_

Purpose of Medication: \_\_\_\_\_

Student understands the proper use of his/her medications, and in my medical opinion, can carry the above medication at school independently with approval from school nurse.

\_\_\_\_\_  
Name of Physician Fax #

\_\_\_\_\_  
Signature of Physician Date

I hereby give permission for \_\_\_\_\_ to possess and self-administer the above medication at school as indicated. I understand that it is my responsibility to furnish this medication which I have labeled with the student's name.

I absolve GWSD of any responsibility in safeguarding our student's medication. If the student demonstrates irresponsible behavior with this medication, this permission can be revoked by the principal.

My student understands the risks of carrying this medication and will not allow another student to use the above medication. If applicable, my student will notify school personnel immediately after use of an epinephrine auto-injector during school hours. Upon receiving such report from a student, the school personnel will provide appropriate follow-up care which shall include making a 911 emergency call.

\_\_\_\_\_  
Signature of Parent/Guardian Date

\_\_\_\_\_  
Signature of Student Date