Written Authorization for Self-Administration of Asthma Medication
by Minor Children at School

Student Name: ____
Date of Birth: ____________________ **Grade:** ____________________

I, ____________________________, Parent/Legal Guardian of the above-named student, hereby request authorization for self-administration and possession of asthma medication by this student while in school, at a school- sponsored activity, while under supervision of school personnel, and while in before-school or after-school care on school operated property. The student demonstrates full understanding of the proper use of his/her asthma medication.

I understand that:

- LCA and its employees and Board of Directors shall incur no liability for: a) any injury to the student caused by his or her self-administration of medication except for injury caused by willful or wanton misconduct; b) the student's use, misuse, overuse, or neglected or failed use of his or her asthma medication; and c) lost, misplaced, outdated, inaccessible, empty, or faulty asthma medication and asthma devices;
- the school may choose to require supervision of medication administration in the event that the student does not demonstrate appropriate use or proper technique with asthma medication;
- the school has the authority to enforce rules and consequences for inappropriate behavior demonstrated by the student in association with the possession and/or self-administration of asthma medication and that the school has the authority to require supervision of medication use as deemed appropriate for the safety of all students and staff.

I take sole responsibility for:

- the monitoring of asthma medication, medication use, and refilling of prescriptions for asthma medication, as the school will not be responsible for the supervising, recording, and monitoring of self-administered asthma medication;
- ensuring the student always carries his/her asthma medication on his/her person;
- providing the school with the back-up medication;
- informing school staff **in writing** of any changes in the student's treatment or asthma management;
- informing the school of any asthma exacerbations, hospital visits, and/or new or changed student medical information;
- informing school staff **in writing** of any medication side effects that warrant communication to the parent/guardian;
- coordinating distribution of the student's asthma management and emergency plan to school staff (school health worker, teachers, physical educators, coaches, bus driver, before-school and after-school staff).

I understand and agree to the conditions of the school policy. I permit the school to seek emergency medical treatment for the student when deemed necessary and appropriate. I accept legal responsibility should the medication be misused or given or taken by a person other than the above named student. I release Loganville Christian Academy and its employees and agents of any legal responsibility related to the above named student's possession and self-administration of his or her asthma medication.

______________________________________ ____________
Parent/Legal Guardian Signature Date

I, ____________________________, the above-named student, have been instructed in the proper use of my prescription asthma medication and fully understand how and when to use this medication. I will always carry my medication with me and will not allow another student to use my medication under any circumstance. I understand and agree to the terms of the school policy.

______________________________________ ____________
Student's Signature Date

The above named student has been instructed and demonstrates understanding of the proper use of his/her asthma medication. It is my professional opinion that the student should be permitted to carry and self-administer his/her asthma medication. I have provided the parent/guardian with a written asthma emergency/management plan including the name, purpose, dosage, and administration directions of the asthma medication.

______________________________________ ____________
Physician's Signature Date

Loganville Christian Academy
Asthma/Reactive Airway / Respiratory Health Plan

Name: ____ Grade ________

Parent/Guardian Name:
1.) ________________________ 2.) ________________________
Phone: ______________________ Phone: ______________________

Emergency Contact: If unable to reach parents Physician Managing Respiratory Condition:

________________________ ________________________

Phone: ______________________ Phone: ______________________

Section to be completed by Physician

☐ Reactive Airway Disease ☐ Asthma ☐ Other ________________

Check all triggers that bring about an episode.

___ Exercise
___ Respiratory Infections
___ Change in Temperature
___ Molds
___ Strong odors or fumes
___ Chalk Dust
___ Carpets in the room
_____ Animals
_____ Food ______________
_____ Pollens

Please list ALL Respiratory medications, dose, and frequency used at home or school.

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When student has these symptoms ____
Inhaler use is necessary.
Student is to use (medication / dose / how often repeated) ______________________
If no relief, emergency treatment is needed:

1. Contact parent.
2. Call 911 if the student has any of the following:
   a. No improvement 15-20 minutes after initial treatment with medication and a relative can or cannot be reached.
   b. Peak flow of ____________________Peak flow meter needed at school
   c. Hard time breathing with:
      - Chest and neck pulled in with breathing
      - Child is hunched over
      - Child is struggling to breath
   d. Trouble walking or talking
   e. Stops playing and can't start activity again
   f. Lips or fingernails are gray or blue

Comments/Special Instructions: ____

FOR INHALED MEDICATIONS:
STUDENT HAS BEEN INSTRUCTED ON PROPER USE OF INHALER AND MAY CARRY INHALER WHILE AT SCHOOL/SCHOOL ACTIVITIES YES NO

________________________ ________________
Physician Signature and office stamp required DATE

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IF STUDENT CARRIES AN INHALER, HE/SHE MUST HAVE A BACKUP INHALER IN THE NURSE'S OFFICE. IF HE/SHE DOES NOT CARRY INHALER WITH THEM, THE INHALER MUST BE LEFT IN THE NURSE'S OFFICE.

________________________ ________________
PARENT SIGNATURE DATE