Cameron ISD Asthma Self-Medication Authorization Form

The following must be provided to the school in order for a student to self-administer asthma medication according to Texas Education Code, Chapter 38, Section 38.015:

- A written statement from the student's licensed healthcare provider that describes the student's medication and confirms their ability to self-administer their prescribed medication
- A written authorization signed by the parent for the student to self-administer the prescription while on school property or at a school related event or activity

Prescriber's Authorization

Student's Name _____ Sex _____

Date of Birth _____ /_____/_____ Teacher/Homeroom _____

Condition for which medication is being administered _____

Medication Name _____ Dose _____ Route _____

Time(s) of day to administer _____

Is this a PRN, (As-needed) Medication? YES☐ NO☐

Medication shall be administered from: ___/____/____ to: ____/____/_____

The student has demonstrated that they are capable of self-administering their medication:

YES ☐ NO ☐

If No, please explain: _____

Prescriber's Name _____ Telephone _____ - _____ - _____

Address _____

Prescriber's Signature _____ Date _____

Parent/Guardian Authorization

I request that school health staff allow my child to self-carry with the intention to self-administer the medication described above by my child's primary prescriber. I agree to notify the school nurse or school health staff and provide a new self-medication authorization form when there is a change in my child's medication, health status, or authorized healthcare provider.

Describe how your child will carry/store their medications:

_____

Parent/Guardian Signature _____ Date

_____

Cell Phone: ____ - ____ - ____ Home Phone: ____ - ____ - ____ Work Phone: ____ - ____ - ____

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School Nurse Authorization

An evaluation of the student's ability to self-administer their asthma is conducted by the school nurse, if a school nurse is available.

Self-Administration Evaluation Date: _____/_____/_____

Is the student capable of self-administration? YES☐ NO ☐

If NO, then please explain: _____

School Nurse Signature _____Date _____

Inform all relevant school staff that this student is permitted/not permitted to self-carry and administer their medication(s) Nurse Initials _____