TAYLOR INDEPENDENT SCHOOL DISTRICT

Parent Authorization of Asthma Medication
Physician Authorization for Self Carry

School Year: _____

FOR SCHOOL STAFF: Please complete all fields below.

Student Name: _____ Grade: _____ Teacher: _____

Medication Name and Strength	Dose to be Administered	Time(s) to be given at school	Dates to be administered	Type of Spacer

FOR PARENTS/GUARDIANS: Please acknowledge the following information and sign.

In order to administer asthma medication in the school health clinic, Taylor ISD requires parent/guardian written permission AND a current asthma action plan from the student's doctor. The asthma medication must be in the original container and properly labeled and cannot be expired. The first dose of this medication may not be given at school.

- I request that the above medication be given during school hours, as prescribed
- I request that this medication also be given on field trips as prescribed, if needed
- I will notify the school of any change in the medication and provide an updated physician
- I give permission for the school nurse to communicate with the student's teachers about my student's health condition
- I give permission for the medication to be administered by personnel designated by the Principal
- I understand that the above form can only be used for the 2024-2025 school year and a new form will need to be completed each year
- **I understand that for my student to be allowed to self carry their asthma medication, TISD also requires physician approval and signature to be provided to the campus nurse. If my student demonstrates that they are unable to reliably and responsibly use their inhaler, the nurse will contact a parent or guardian and the privilege may be revoked.**

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____ Date: _____

FOR PHYSICIANS: Fill out ONLY for students that are authorized to self carry their asthma medication.

In my opinion, the above mentioned student is able to reliably, responsibly, and safely use their asthma inhaler, as needed, while at school or at school related activities. I authorize them to self carry their asthma medication and spacer.

Physician Printed Name: _____ Physician Signature: _____

Date: _____