MORAGA SCHOOL DISTRICT
SCHOOL MEDICATION AUTHORIZATION FORM

ASTHMA INHALER/EPIPEN PRESCRIPTION MEDICATION

MEDICATION DURING SCHOOL HOURS
This form must be completed by the physician and the parent/guardian and contain their signatures before any medication can be administered at school. THE PARENT OR ADULT REPRESENTATIVE MUST BRING ALL MEDICATIONS TO SCHOOL IN THE ORIGINAL CONTAINER.

I. THIS SECTION TO BE COMPLETED BY PHYSICIAN

Name of Student: _____ Date of Birth:_____

Name of Medication:_____ Dosage:_____

Reason for Medication:_____

Please check one: Inhaler:_____ Epipen: _____

Time to be Administered:_____ Start Date:_____ Stop Date:_____

Restrictions and/or important side effects:
_____

Printed name of physician:_____

Address:_____Phone:_____

SIGNATURE OF PHYSICIAN: _____ Date: _____

II. THIS SECTION TO BE COMPLETED BY PARENT/GUARDIAN

I give permission for (name of child) _____ to receive the above medication at school according to standard school policy. I, or an adult representative whom I designate, will bring all prescription medications to school. I also give permission to contact the above named physician regarding any questions that may arise with regard to the medication. I agree to, and do hereby hold the District and its employees harmless from any and all claims, demands, causes of action, liability or loss of any sort of or arising out of acts or omissions of the District or its employees with respect to this medication.

Signature of Parent/Guardian:_____ Date: _____

Home Phone:_____ Emergency Phone _____

Staff Signature: _____ Date Received: _____

Med Exp Date: _____ Date Picked Up/Disposed Of: _____

III. PERMISSION TO CARRY ASTHMA INHALERS/EPIPENS

(SECTIONS I AND II MUST BE COMPLETED)

TO BE COMPLETED BY THE PHYSICIAN:

The student named in Section I has been instructed in the proper use of their asthma inhaler/emergency medication. The child's well-being is in jeopardy unless this medication is carried on his/her person. Therefore, I request that he/she be permitted to carry the asthma inhaler/emergency medication at school. He/she understands the purpose, appropriate method, and frequency of use of the asthma inhaler/emergency medication.

NAME OF MEDICATION: _____

PHYSICIAN'S SIGNATURE: _____

DATE:_____

TO BE COMPLETED BY THE PARENT/GUARDIAN:

I permit my child to carry the above-listed asthma inhaler/emergency medication as ordered by his/her physician.

PARENT/GUARDIAN SIGNATURE: _____

DATE: _____

TO BE COMPLETED BY STUDENT:

I have been instructed in the proper use of my medication and will take it as prescribed to me by my physician.

STUDENT'S SIGNATURE: _____

DATE:_____