

**Request for Self-Administration of Medication (Inhaler)**

**Notice to Parents: Medication must be brought to school by parent or legal guardian in a container that is appropriately labeled by the pharmacy or physician.**

Name of Student (Last, First, MI)		Date of Birth	Home Phone # -----
			Parent Work #
Diagnosis		Medication	
Dosage	When should inhaler be used?		Frequency with which it is to be administered.
Route of Administration and Instructions			
Start Date (must be renewed yearly)		End Date	

*In accordance with the Code of Virginia Section 22.1-274.2 by signing this form I attest to the student's demonstrated ability to safely and effectively self-administer inhaled asthma medications and of the student's understanding that if self-administered medication, as prescribed, does not relieve the asthmatic symptoms, the student should report to the school nurse. If she is not available then the student should report to the principal or his designee.*

*I further agree to prepare a written individual health care plan in consultation with the student's parents, and appropriate school personnel.*

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Physician/Nurse Practitioner Signature

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Date

Physician/Nurse Practitioner (please print)

Address & Phone Number

**In accordance with the Code of Virginia Section 22.1-274/2, I agree to the following:**

**I hereby give permission for the school to administer the medication as prescribed above.**

**I also give permission for the school to contact the above health care provider regarding the administration of this medication and the development of a health care plan.**

**I will not hold the school board or any of its employees liable for any negative outcomes resulting from the self-administration of asthma medication by the student.**

**I understand that the school principal may impose reasonable limitations or restrictions upon a student's possession and self-administration of inhaled asthma medication relative to the age and maturity of the student or to other relevant considerations.**

**I understand that the school principal may revoke permission to possess and self-administer inhaled asthma medication at any point during the school year if it is determined the student has abused the privilege of possession and self-administration or that student is not safely and effectively self-administering the medication.**

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**I understand that the school principal may impose reasonable limitations or restrictions upon a student's possession and self-administration of inhaled asthma medication relative to the age and maturity of the student or to other relevant considerations.**

**I understand that the school principal may revoke permission to possess and self-administer inhaled asthma medication at any point during the school year if it is determined the student has abused the privilege of possession and self-administration or that student is not safely and effectively self-administering the medication.**

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Parent/Guardian Signature

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Date

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Route of Administration and Instructions			
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Date

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Parent/Guardian Signature

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Date

**Request for Self-Administration of Medication (Inhaler)**

**Notice to Parents: Medication must be brought to school by parent or legal guardian in a container that is appropriately labeled by the pharmacy or physician.**

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			Parent Work #
Diagnosis		Medication	
Dosage	When should inhaler be used?		Frequency with which it is to be administered.
Route of Administration and Instructions			
Start Date (must be renewed yearly)		End Date	

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*I further agree to prepare a written individual health care plan in consultation with the student's parents, and appropriate school personnel.*

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Physician/Nurse Practitioner Signature

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Date

Physician/Nurse Practitioner (please print)

Address & Phone Number

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**I hereby give permission for the school to administer the medication as prescribed above.**

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**I will not hold the school board or any of its employees liable for any negative outcomes resulting from the self-administration of asthma medication by the student.**

**I understand that the school principal may impose reasonable limitations or restrictions upon a student's possession and self-administration of inhaled asthma medication relative to the age and maturity of the student or to other relevant considerations.**

**I understand that the school principal may revoke permission to possess and self-administer inhaled asthma medication at any point during the school year if it is determined the student has abused the privilege of possession and self-administration or that student is not safely and effectively self-administering the medication.**

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**I will not hold the school board or any of its employees liable for any negative outcomes resulting from the self-administration of asthma medication by the student.**

**I understand that the school principal may impose reasonable limitations or restrictions upon a student's possession and self-administration of inhaled asthma medication relative to the age and maturity of the student or to other relevant considerations.**

**I understand that the school principal may revoke permission to possess and self-administer inhaled asthma medication at any point during the school year if it is determined the student has abused the privilege of possession and self-administration or that student is not safely and effectively self-administering the medication.**

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Parent/Guardian Signature

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Date

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			Parent Work #
Diagnosis		Medication	
Dosage	When should inhaler be used?		Frequency with which it is to be administered.
Route of Administration and Instructions			
Start Date (must be renewed yearly)		End Date	

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Physician/Nurse Practitioner Signature

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Physician/Nurse Practitioner (please print)

Address & Phone Number

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Physician/Nurse Practitioner (please print)		Address & Phone Number	
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**Notice to Parents: Medication must be brought to school by parent or legal guardian in a container that is appropriately labeled by the pharmacy or physician.**

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			Parent Work #
Diagnosis		Medication	
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**I understand that the school principal may impose reasonable limitations or restrictions upon a student's possession and self-administration of inhaled asthma medication relative to the age and maturity of the student or to other relevant considerations.**

**I understand that the school principal may revoke permission to possess and self-administer inhaled asthma medication at any point during the school year if it is determined the student has abused the privilege of possession and self-administration or that student is not safely and effectively self-administering the medication.**

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Parent/Guardian Signature

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Date



**Request for Self-Administration of Medication (Inhaler)**

**Notice to Parents: Medication must be brought to school by parent or legal guardian in a container that is appropriately labeled by the pharmacy or physician.**

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Diagnosis		Medication	
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Route of Administration and Instructions			
Start Date (must be renewed yearly)		End Date	
<p><i>In accordance with the Code of Virginia Section 22.1-274.2 by signing this form I attest to the student's demonstrated ability to safely and effectively self-administer inhaled asthma medications and of the student's understanding that if self-administered medication, as prescribed, does not relieve the asthmatic symptoms, the student should report to the school nurse. If she is not available then the student should report to the principal or his designee.</i></p> <p><i>I further agree to prepare a written individual health care plan in consultation with the student's parents, and appropriate school personnel.</i></p>			
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Physician/Nurse Practitioner (please print)		Address & Phone Number	
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