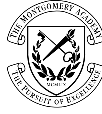
FOR SCHOOL USE ONLY
Date Received: __________
Approved By: __________
For School Year: _________



The Montgomery Academy
Parent/Legal Guardian Acknowledgement
Student Self-Administration of Asthma Medication

I hereby affirm that my child ____ is currently enrolled as a student at The Montgomery Academy and is currently being treated for asthma under the care of a physician.

I also affirm that he/she has been instructed in the proper self-administration of the prescribed asthma by his/her attending physician.

As his/her parent/legal guardian, I understand that the permission for the self-administration of asthma medication(s) shall only be effective for the school year in which the permission is given, and that permission may be granted in subsequent years for my child provided that the required forms are re-submitted each school year.

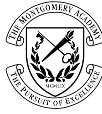
I understand that upon obtaining permission to self-administer the prescribed asthma medication(s), my child shall be permitted to possess and self-administer the prescribed asthma medication(s) at any time while on school property or while attending a school-sponsored activity.

I also hereby acknowledge that as the parent/legal guardian of ____________________________________, I shall indemnify and hold harmless the school, the agents of the school, and the local board of education against any claims that may arise relating to my child's self-administration of prescribed asthma medication(s).

____________________________________ **SIGNATURE** of parent/legal guardian

____________________________________ **PRINTED** name of parent/legal guardian

Date: ______________________________



The Montgomery Academy
Medical Authorization
Student Self-Administration of Asthma Medication

____ is currently a patient under my care being treated for asthma.

I hereby affirm that he/she has been instructed in the proper self-administration of the prescribed asthma medication(s) listed below:

Name of medication(s):____

Prescribed dosage(s):____

Frequency with which the prescribed medication(s) is/are to be administered:_______________________

____

The length of time for which the medication(s) is/are prescribed for: _____________________________

____

SPECIAL INSTRUCTIONS OR CIRCUMSTANCES, IF ANY, UNDER WHICH THE MEDICATION(S) SHOULD BE ADMINISTERED:

____

____

____

____

____________________________________ ____________________________________

SIGNATURE of attending physician or his/her authorized agent

PRINTED name of attending physician or his/her authorized agent

Office Address:

Date: ______________________________

____

____

____

Phone: (________)____________________

Parent/Legal Guardian Acknowledgement

ACT NO: 2003-271