Pharr-San Juan-Alamo ISD Health Services

PERMIT FOR SELF-ADMINISTRATION OF ASTHMA OR ANAPHYLAXIS MEDICATIONS
PERMISO PARA DAR MEDICINAS DE ASMA O ANAFILAXIS SIN AYUDA

School Year _____

Student _____ ID # _____

Grade/Teacher _____ Medication allergies _____

HEALTHCARE PROVIDER

It is my professional opinion that the above-named student should be allowed to carry and self-administer the following asthma or anaphylaxis medications while on school property or at school-related events. I have instructed this student in the proper way to use his/her medication(s).

Medication Name:_____

Purpose: _____

Dosage/Frequency:_____

Use for these symptoms: _____

Additional instructions:_____

Medication Name:_____

Purpose: _____

Dosage/Frequency:_____

Use for these symptoms: _____

Additional instructions:_____

Healthcare Provider Signature _____ Date_____

Clinic Name _____Phone number _____

PARENT OR GUARDIAN/*PADRE O GUARDIÁN*

I understand that my child will be using the above-named medication without supervision from school personnel and that I am responsible for ensuring that my child has his/her medication. I have been told that it is recommended that I provide a back-up of my child's medication to be kept in the school nurse's office. For safety reasons, I agree that school personnel may remove this medication from my child if it is not being used as prescribed.

Entiendo que mi hijo/a va a usar la medicina indicada arriba sin supervisión de personal escolar y que es mi responsabilidad asegurar que mi hijo/a traiga su medicina. Se me ha recomendado traer otro (extra) de la medicina y mantenerlo en la enfermería para uso en caso de que mi hijo/a no traiga el suyo. Por razones de seguridad, estoy en acuerdo que el personal escolar puede quitarle esta medicina a mi hijo/a si no la usa como recetada.

Parent/Guardian Signature Date
*Firma de Padre/Guardián*_____ *Fecha*_____

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