FORT BEND INDEPENDENT SCHOOL DISTRICT
Parent-Physician Permit to Carry Asthma and Anaphylaxis Emergency Medication

Student _____ Grade _____ DOB _____

Teacher (for elementary use) _____ Allergies _____

Medication_____ Strength_____ Dose_____

Frequency _____ as needed or scheduled time: _____

Start date to be given: _____ End date to be given: _____(Valid for current school year only)

Number of pills or tablets _____ Expiration date of medication _____

Reason student is receiving medication:_____

Possible reactions or restrictions: _____

My student is capable of self-administration of the above medicine. I authorize my student to self-administer this emergency medication according to doctor's orders while on school property or at a school-related event or activity. I understand that my student is responsible for the proper handling and carrying of this medication and that it must be kept out of the reach of other students at all times. The medication must have a current prescription label indicating that it has been prescribed for my student.

The school nurse has my permission to consult Dr. _____ with questions regarding this medication.

Parent/Guardian Signature_____ Date_____

Home Phone # _____ Daytime phone # _____

Comments: _____

_____

This student has demonstrated the knowledge and skill level necessary to self-administer this medication and in my professional opinion, this student should be allowed to carry this emergency medication/inhaler as well as to self-administer and manage his/her emergency treatment while at school or school related events.

_____ _____ _____
Physician's Name (Print) Telephone # Fax #

_____ _____
Physician's signature Date