GLASSBORO PUBLIC SCHOOLS
SCHOOL HEALTH SERVICES

PARENT AUTHORIZATION FOR SELF-ADMINISTRATION OF ASTHMA INHALERS

ASTHMA MEDICATION- SELF ADMINISTRATION ONLY (must be authorized by physician)
Parent/Guardian Certification for Self- Administration of Medication in School

I am requesting that my child _____ be permitted to self-administer the asthma medication as prescribed by his/her physician for in school use for a life-threatening condition. I understand that this request is valid only for this school year. I further understand that neither the Glassboro Board of Education, nor any district employee shall be responsible for any liability or injury arising from the self-administration of this medication by my child.

I have received a copy of and agree to comply with Guidelines for Administration of Medication in School. I understand that a new medication order will be required for any medication, dosage or time changes and understand that medication must be brought to school by parent/guardian or adult pupil in original container with prescription label attached.

NEITHER THE GLASSBORO BOARD OF EDUCATION, NOR ANY DISTRICT EMPLOYEE SHALL BE RESPONSIBLE FOR ANY LIABILITY AS A RESULT OF ANY INJURY TO THE ABOVE NAMED STUDENT, ARISING FROM THE SELF-ADMINISTRATION OF MEDICATION OR ANY MISUSE OF THE MEDICATION.

PLEASE ADVISE YOUR CHILD TO REPORT USAGE OF INHALER TO THE SCHOOL NURSE SO THAT AN APPROPRIATE ASSESSMENT OF HIS/HER RESPIRATORY STATUS CAN BE OBTAINED.

Parent Name (print) _____

Parent Signature _____Date _____

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