

MARION INDEPENDENT SCHOOL DISTRICT

Student Personnel

Series 500

Policy Title ADMINISTRATION OF MEDICATION TO STUDENTS Code No. 504-1-E2

**Marion Independent School District
Authorization for Student's to Self Administer
Asthma Medication**

Student _____ Birthdate _____

School _____ Start Date _____

- I request the above student possess and self-administer Asthma medication at school and during school activities according to the authorizations and instructions.
- I understand the school district and its employees acting reasonably and in good faith shall incur no liability for any improper use of this medication or for supervising, monitoring, or interfering with a student's self-administration of this medication.
- I agree to coordinate and work with school personnel and notify them when questions arise or relevant conditions change.
- I agree that I/my child will assume full responsibility for safe delivery/use/monitoring of this medication.
- I agree this information will be shared with school personnel in accordance with the Family Education Rights and Privacy Act (FERPA).
- If needed, I agree to provide the school with back-up medication approved in this form.

Parent Signature _____ Date _____

Parent Daytime Phone _____

I request that the above named student be allowed to carry and self-administer his/her Asthma medication.

Physician Signature _____ Date _____