# PARENT'S REQUEST FOR STUDENT WITH ASTHMA AND/OR LIFE THREATENING ALLERGY TO POSSESS AND SELF-ADMINISTER PRESCRIPTION ASTHMA AND/OR ANAPHYLAXIS MEDICINE WHILE ON SCHOOL PROPERTY OR AT A SCHOOL-RELATED EVENT OR ACTIVITY

**(Parent to fill out information below and sign)**

1) Name of Pupil _____

2) Grade:_____ D.O.B. _____

3) Condition/s for which the drug/s to be given: _____
_____

4) Physician's Name (Please Print): _____

I REQUEST THAT MY ABOVE NAMED CHILD BE ALLOWED TO CARRY ON HIS/HER PERSON AND SELF-ADMINISTER HIS/HER PRESCRIPTION MEDICATIONS LISTED BELOW AS PRESCRIBED PER HIS/HER PHYSICIAN. I UNDERSTAND THAT THE MEDICATION MUST HAVE MY CHILD'S NAME ON THE PRESCRIPTION LABEL. I UNDERSTAND THAT I AM RESPONSIBLE FOR PROVIDING TO THE SCHOOL THE DOCTOR'S SIGNED AUTHORIZATION AS BELOW.

5) Parent or Legal Guardian's Signature: _____

6) Daytime phone number:_____ Date: _____

**(Physician to fill out information below and sign)**

7) Name and purpose of medication #1:_____

8) Dosing instructions for medication#1:_____
_____

9) Name and purpose of medication #2:_____

10) Dosing instructions for medication #2: _____
_____

11) Special Instructions: _____
_____

**Physician's Signature**: _____ Date: _____
Physician's phone number _____