MILWAUKEE MONTESSORI SCHOOL

Established 1961

Authorization to Self-Administer ***Asthma*** Medication - 4th -8th grade students only.

Milwaukee Montessori School students may self administer prescription medications under conditions established by the School. Students may not administer any over-the-counter medications. This authorization must be completed, signed and on file before any medication may be at school. A complete set of non-expired medication and/or inhaler must be given to the office. **All conditions must be met before the child can attend school, and this information must be included in MyBackPack.**

Please emphasize with your child that he/she may not share this medication with another student. If a student does not show appropriate responsibility in carrying this medication, the privilege of carrying an inhaler will be revoked and the inhaler will be kept by school personnel. Students must be able to determine when they need the medication. The School will not carry this medication when the student is engaged in any School activity outside of the building.

Student's Name: _____ Class:_____

Prescribing Physician's Name: _____ Dr's Phone#:_____

Medication: _____ Dosage:_____

Time/Frequency to be used: _____ How often repeated: _____

Does your child carry this medication? _____ Where is it kept? _____

Does your child know how to use this medication appropriately? _____

Does your child know to seek help from school staff for his/her asthma or if the medication is not effective? _____

If given on an "as needed" basis, describe circumstances (e.g. signs or symptoms child exhibits) under which it is to be given:
_____

When may it be repeated if given on "as needed" basis? _____

Special Instructions:_____

Side effects that would require notification of parent/guardian or physician:_____

_____

I give permission for my child to carry and self-administer his/her asthma medication (inhaler).

_____ _____

Parent/Guardian's Signature *Date*

_____ _____

Physician's Signature *Date*

Physicians Comments: _____

I give consent for school personnel who are involved in dispensing my child's medication at school to contact my child's physician regarding any questions about the administration of the medication listed above. This consent is valid for one year from the date of the signature.

_____ _____

Parent's Signature *Date*