W.E.B. DU BOIS CONSORTIUM OF CHARTER SCHOOLS

AUTHORIZATION FOR MEDICATION DURING SCHOOL

Please Complete All Information

Student Name _____ **School Name** _____

Social Security # _____ **Academic Year** _____

Date of Birth _____ **Sex** _____

THE FOLLOWING IS TO BE COMPLETED BY THE PHYSICIAN

Diagnosis for which medication is given: _____
(i.e., Behavioral, Seizure, Asthma, Diabetes)
Name of Medication _____ Dosage _____
Form (Pill, Liquid, Inhaler) _____
List significant side effects _____
Length of time medication prescribed? _____

☐ The undersigned hereby verifies that the cooperation of school personnel in assisting with this medication is necessary in order to permit the student to maintain regular school attendance.

☐ The undersigned hereby verifies that the above student suffers from asthma and has been instructed in self-administration of the prescribed, metered dosage, asthma-reliever inhaler.

_____ _____
Physician's Signature Date

_____ _____
Physician's Name (Print) Telephone

I request that my child be allowed to take his/her medication as authorized by the physician and me. I understand that, although a reasonable attempt will be made to remind the student, it is expected that the student will be responsible for obtaining his/her medication.

In the case of the administration of prescribed, metered dosage, asthma inhalers:

- ☐ **I do not want my child to self-carry his/her asthma inhaler**
- ☐ **I want my child to self-carry his/her asthma inhaler**

I agree to indemnify and hold harmless W.E.B. Du Bois Consortium and its employees from claims relating to the possession of self-administration of asthma in halers, and understand that W.E.B. Du Bois Consortium, its employees and agents shall incur no liability as a result of injury to a student or any other person as a result of possession of self-administration of asthma inhalers.

I also authorize the school's registered nurse to consult with the prescribing physician to clarify this medication order, or in the interest of the student's health, to discuss his/her response to the prescribed medication. All health information will be kept confidential.

_____ _____ _____
Date **Parent/Legal Guardian Signature** **Telephone**

Date Discontinued _____

The W.E.B Du Bois Consortium of Charter Schools does not discriminate in its programs or employment on the basis of race, color, religion national origin, handicap/disability, sex or age.

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