

**AUTHORIZATION FOR SELF-ADMINISTRATION OF ASTHMA MEDICATIONS  
BY STUDENTS IN THE COLUMBUS MUNICIPAL SCHOOL DISTRICT**

I/We, the undersigned parent(s) or guardian(s) of \_\_\_\_\_, authorize the school/school district to permit my/our child to self-administer asthma medications. I/We understand that is my/our responsibility to provide the proper medication to my/our child, to insure that my/our child carries his/her medication with them, and that my/our child is properly instructed on the self-administration of the medication. I/We understand that a written statement must accompany this authorization from my/our child's health care practitioner verifying that he/she has asthma and has been instructed in self-administration of asthma medications. The statement must also contain:

1. The name and purpose of the medication;
2. The prescribed dosage;
3. The times at which or circumstances under which the medications are to be administered;
4. The length of time for which the medications are prescribed;
5. The signature of the child's health care practitioner; and
6. The date the statement was signed.

**RELEASE AND INDEMNITY AGREEMENT:** I/We forever release, discharge and covenant to hold harmless the Columbus Municipal School District, its personnel, agents, employees, volunteers, and Board of Trustees from any/all liability claims, demands, damages, expenses, loss of services, and causes of action belonging to my/our child or to the undersigned arising out of or on account of any injury, sickness, disability, death, loss of damages of any kind resulting from self-administration of the asthma medicines except in cases of willful or wanton conduct.

I/We agree to repay the school district, its personnel, agents, employees, volunteers, or Trustees any sum of money, expenses, or attorney's fees that any of them may be compelled to pay in defense of any action or on account of any such injury or death to my/our child as a result of self administration of the asthma medicines except in cases of willful or wanton conduct.

I/We have read the foregoing release and indemnity agreement and fully understand it.

Executed this the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

**\*\*CHILD REQUIRES ASSISTANCE IN ADMINISTERING ASTHMA MEDICATION. (Yes \_\_\_\_ No \_\_\_\_)**

_____	_____
Witness	Parent/Guardian
_____	_____
Witness	Parent/Guardian

**PHYSICIAN'S AUTHORIZATION FOR SELF ADMINISTERED ASTHMA MEDICATION**

Dear Dr. \_\_\_\_\_

The policy of the Columbus Municipal School District and current state law regarding the matter of self-administration of asthma medication requires a written statement from the student's physician or health care provider, indicating that the student has asthma and has received instructions in self-administration of asthma medication. Medications that are administered at school must be properly labeled as to substance, dosage, and patient name. Written authorization from the student's parent/guardian is also required. Sincerely,

Billie Beard, RN Stokes-Beard Ph#-241.7270 Fax-241.7272	Sharon Reifers, RN Franklin & CMSD Alt Ph#-241.7150 Fax-241.7152	Katie Elliott, RN Cook Elementary Ph#-241.7180 Fax-241.7182	Marlisia Pierce, RN Sale & Fairview Ph#-241.7260 Fax-241.7262	Maris Braddock, RN Columbus Middle Ph#-241.7300 Fax-241.7305	Shonenn Fant, RN Columbus High Ph#-241.7200 Fax-241.7208
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**TO BE COMPLETED BY THE PHYSICIAN**

\_\_\_\_\_ has received instructions in the self-administration of \_\_\_\_\_  
Patient's Name Medication  
 for asthma, and is to self-administer \_\_\_\_\_ of this medication at \_\_\_\_\_.  
Dosage Date/Time

SIDE EFFECTS: \_\_\_\_\_

TERMINATION DATE: \_\_\_\_\_ COMMENTS/CONDITIONS: \_\_\_\_\_

_____	_____
Name of Physician (Please Print)	Signature of Physician
_____	_____
Telephone Number/Fax Number	Street Address, City