

**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 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 time(s) the medications are to be regularly administered and under what additional special circumstances the medications are to be administered;
4. The length of time for which the medications are to be 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, 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.

I/We agree to repay the school district, its personnel, 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.

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

Executed this the _____ day of _____, 200_____.

Witness

Witness

Parent/Guardian

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, indicating that the student has asthma and has received instructions in self administration of asthma medication. Medications that are administered at school must be in properly labeled container or prescription bottle. 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 Fairview/Franklin/Sale Ph#-241.7150 Fax-241.7152	Katie Elliott, RN Cook Elementary Ph#-241.7180 Fax-241.7182	Marlisa Pierce, RN Hunt Intermediate Ph#-241.7160 Fax-241.7164	Maris Braddock, RN Lee Middle Ph#-241.7300 Fax-241.7305	Carrie Dozier, 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)

Telephone Number/Fax Number

Signature of Physician

Street Address, City, School