

TRI-CITY CHRISTIAN ACADEMY

Request for Student to Carry and Self-Administer Asthma Inhaler

School Year _____

Physician's Statement

(to be completed and signed by physician)

Child's Name _____ Diagnosis _____

Medication _____ Dosage _____

Administration Instructions _____

Physician's Name _____

Office Phone Number _____

I certify that the above student has demonstrated the ability to properly self-administer the medication above and understands the safety factors and responsibilities related to having the medication in his/her possession at school.

Physician's Signature _____ Date _____

Parent's Statement

I authorize my child to carry the above medication at school for the purpose of self-management of his/her asthma symptoms, in compliance with TCCA policies in order to ensure the health and safety of all the students in the school. I understand that this is a privilege, which can be revoked if my child fails to handle his/her inhaler in a responsible manner. I further understand the TCCA faculty/staff are not responsible for ensuring that the medication is taken and that this form is valid for only the current school year indicated above.

Parent's Signature _____ Date _____