GCA GENERATIONS CHRISTIAN ACADEMY

Authorization for Self-Administration of Asthma/Allergy Medication

Parent/guardian, please complete the following:

Student name _____ Date of Birth_____

Teacher name _____Grade_____

Parent/guardian name _____ Cell Phone _____

Prescribing Health Care Provider _____ Phone _____

Name of Medication/Strength _____

Description of condition/reason for medication _____

Time(s) to be given at school _____ Dosage _____

How is medication to be taken? _____

Anticipated length of treatment _____

Possible adverse reactions _____

Additional information: _____

(Student's name) _____ has ____asthma and/or ___allergies that are potentially life-threatening and is treated with prescription medication that must be carried by the student. He/she is capable of administering their own medication at school and at school-related activities. School administration and staff will be informed of any changes to the medication specified on this form, to the dosage, or to the recommended regimen by an updated version of this consent form. The student understands that the misuse of any medication or medical equipment that could and recklessly cause harm to another student will result in disciplinary action.

Parent/guardian signature _____ Date _____

Student signature_____ Date _____