



ASTHMA MEDICATION AUTHORIZATION FORM

IF YOUR SON HAS ASTHMA, THIS FORM MUST BE COMPLETED, SIGNED AND RETURNED TO STUDENT SERVICES NO LATER THAN SEPTEMBER 3, 2018.

STUDENT NAME: _____ STUDENT I.D. # _____
(PRINT): Last First Middle

ASTHMA MEDICATIONS LAW (HB353)

Kentucky House Bill 353 allows students with asthma to have unobstructed access to asthma medications. The key points of this law are as follows:

Public and private school students are allowed to possess and use asthma medications, provided that:

- The student has written authorization from a parent and his health care provider to self-administer his asthma medications.
- The written authorization is kept on file at school.
- A parent or guardian must sign a statement acknowledging that the school has no liability from any injury sustained by a student from self-administration of medication.

Permission for self-administration of medications is effective for the current school year and must be renewed each school year.

If you have any questions regarding this law or any asthma issue, please contact the Director of Education & Advocacy, American Lung Association, at 363-2652.

Saint Xavier High School and its employees shall incur no liability as a result of any injury sustained by the student from self-administration of asthma medications.

IF YOUR SON HAS ASTHMA, BUT DOES NOT NEED TO SELF-ADMINISTER ASTHMA MEDICATIONS AT SCHOOL, COMPLETE AND SIGN ONLY THIS SECTION OF THE FORM AND HAVE YOUR SON RETURN THE SIGNED FORM TO STUDENT SERVICES

I, _____, parent/guardian of the above named student, verify that my son has asthma, but does not need to carry or self-administer any asthma medications at school, at school-sponsored activities or at any time that he is present on Saint Xavier High School's property.

X _____
Parent/Guardian Signature Date

IF YOUR SON HAS ASTHMA AND HE MUST SELF-ADMINISTER ASTHMA MEDICATIONS AT SCHOOL, YOU AND THE STUDENT'S HEALTH CARE PRACTITIONER MUST COMPLETE AND SIGN ALL SECTIONS BELOW. YOUR SON MUST RETURN THE COMPLETED FORM TO STUDENT SERVICES BEFORE HE WILL BE GIVEN PERMISSION TO SELF-ADMINISTER HIS ASTHMA MEDICATIONS ON SCHOOL PROPERTY OR AT ANY SCHOOL-SPONSORED ACTIVITY.

I, _____, parent/guardian of the above named student, authorize Saint Xavier High School to allow the student to carry with him and self-administer his asthma medications.

X _____
Parent/Guardian Signature Date

I, _____, parent/guardian of the above named student, acknowledge that Saint Xavier High School shall incur no liability as a result of any injury sustained by the student from the self-administration of asthma medications. I further indemnify and hold harmless Saint Xavier High School and its employees against any claims relating to the student's self-administration of asthma medications.

X _____
Parent/Guardian Signature Date

IF YOUR SON HAS ASTHMA AND HE MUST SELF-ADMINISTER ASTHMA MEDICATIONS AT SCHOOL, THE STUDENT'S PHYSICIAN MUST COMPLETE THE FOLLOWING SECTION AND SIGN WHERE INDICATED.

I, _____, verify that _____ has asthma
Physician/Health Care Provider's Name (please print) Student's Name (please print)

and the student has been instructed in self-administration of the asthma medications listed below:

Name of Asthma Medication	Purpose of Medication	Prescribed Dosage	Time(s) or circumstances under which medication must be administered	Length of time for which medication is prescribed
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

X _____
Physician / Healthcare Provider Signature Date