

Request for Child to Carry and Administer Own Prescription Medication by Inhaler

- Have the child's physician complete and sign this form.
- Parent or guardian must complete and sign their portion of this form.
- This form must be on file in the child's file at the school site before child may self-administer medication by inhaler. A separate form is required for each medication.

Physician's Section:

Physician's name: _____ Physician's phone number: _____

This is to certify that _____ (child's name) is under my care and should be allowed to carry and administer his/her own personal medication by inhaler. I hereby stipulate that the immediate administration of medication during bronchial spasm is medically necessary and that even a five-minute delay in administering that medication could lead to serious medical complications. I hereby represent that the immediate administration of medication during bronchial spasm(s) is medically indicated and that a delay in such administration could have significantly adverse medical consequences. I further stipulate that the above-named child has been instructed and demonstrates knowledge of the proper circumstances in which this medication should be administered as well as the proper care, storage and administration of the below-indicated medication.

Medication	
Special Instructions	
Possible Side Effects	
Starting Date for Medication	
Expiration Date of this Request	

(Physician's Signature)

(Date)

Parent's Section:

I hereby make request and give my permission for my child to carry an inhaler and to administer his or her own medication therefore in keeping with the Physician's Section above. Further, I hereby release from liability, and in addition agree to indemnify all employees of Dublin Latchkey for damages or injury resulting from the use, misuse or nonuse of such medication except if the employee of Dublin Latchkey is grossly negligent or engages in reckless misconduct.

I further agree to submit a revised statement signed by the physician who has prescribed the medication described in the Physician's Section above in the event that I become aware that any of the information set forth in that section has changed.

(Please turn over)

I have read and understand the policy of Dublin Latchkey, Inc for the administration of medication and affirm that this request entails special circumstances justifying an exception from the usual administration of medication by Dublin Latchkey employees.

Name of Child: _____

Home Address: _____

School: _____

Date: _____

(Parent's Signature)

(Parent Daytime Phone Number)