

REQUEST AND RELEASE
Self-Administration of Medication by Student
ASTHMA/LIFE THREATENING CONDITIONS

The undersigned hereby requests for the child hereinafter named to self-administer the prescribed medication(s) listed hereinafter for treatment of the child's asthma/life threatening condition.

I agree to provide all such medication at my expense. I further agree that according to state law, it is my responsibility to supply the school with an emergency supply of the prescribed inhaler or other medications such as glucagon, epi-pen, etc., as needed for life threatening conditions, and that if I fail to do this and my child is without an emergency supply of the prescribed medication, the school is not liable. I further agree that, in the event of any change in the health or condition of the child, I will promptly notify the school and advise in writing whether there is to be any change in the administration of such medication. I further agree that, in the event of a change of physician for the child, I will obtain from the new physician a new written statement concerning administration of prescription medication to the child. I understand that this *Request and Release* form is effective for the school year for which it is granted and **must be renewed by the parent/guardian each subsequent school year.**

I hereby release Independent School District Number 1 of Oklahoma County, Oklahoma, the District commonly referred to as Putnam City Schools, its officers and its employees, from any and all liability resulting from the child's failure to administer the medication indicated below. I further hereby release Independent School District Number 1 of Oklahoma County, Oklahoma, its officers and its employees, from any and all responsibility for adverse effects of this medication and agree to indemnify them, or any of them, against any and all liability, loss or damage they or any of them may incur as a result of the child not properly self-administering the medicine.

Name of Child _____

Name of Physician _____

Name of Medication Prescribed _____

Dosage _____

Number of Times in School Day To Be Administered _____

Time or Times of Administration _____

To Be Administered Until (Date) _____

Physician's Statement:

_____ I have instructed _____ in the proper use of his/her medication(s), and it is my professional opinion that this child should be allowed to carry and use that medication by him/herself.

_____ It is my professional opinion that _____ should **not** carry his/her medication him/herself.

Physician's **PRINTED** Name

Physician's **Signature**

Date

Parent/Guardian **PRINTED** Name
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Parent/Guardian having legal custody **Signature**

Date