EXHIBIT C (PAGE 2)

MIDLAND INDEPENDENT SCHOOL DISTRICT HEALTH SERVICES DEPARTMENT

AUTHORIZATION FOR STUDENT SELF CARRY AND SELF ADMINISTER ASTHMA MEDICATION

Student Name: _____ DOB: _____
Homeroom Teacher: _____ Grade/Student ID#: _____
Home #: _____ Work #: _____Cell _____
Emergency Contact: _____
Home #: _____ Work #: _____ Cell #: _____
PRINT Parent /Guardian First and Last Name

_____
Parent/Guardian Signature

_____
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Physician Please Check:

____ It is my professional opinion that _____ should be allowed to Carry and Self-Administer the following medication(s) at school or school related events for management of his/her Severe Allergy. This student has been instructed in the proper way to use his/her medication(s) and understands that these medications cannot be shared with any other person.
Medication Name: _____ Dose: _____
When to use: _____

How often can mediation be repeated? _____At what interval? _____

Additional instructions:
_____

Physician Signature:

_____

Print Physician's Name: _____ Date: _____

Office #: _____ Fax #: _____