Venus Independent School District

VENUS INDEPENDENT SCHOOL DISTRICT
REQUEST FOR INHALER SELF-ADMINISTRATION
ON SCHOOL PROPERTY, RELATED EVENT OR ACTIVITY

Name of Student_____ DOB _____

I hereby request and give permission to the above named student, that he/she has asthma and is capable of self-administering the following prescription asthma medication:

Name of Medication _____

Purpose of Medication _____

Prescribed Dosage _____

Time or circumstance medication may be administered

_____

Prescribing Physician _____

Physician's Phone Number _____

MEDICATION MUST BE IN ORIGINAL CONTAINER
WITH PRESCRIPTION LABEL ATTACHED TO DISPENSER

Parent/Guardian Signature _____ Date _____