SELF-ADMINISTRATION CONSENT FORM

NAME OF STUDENT:		DATE OF BIRTH:
ADDRESS:	ESS: EMERGENCY PHONE:	
SCHOOL:	GRA	NDE:
PHYSICIAN'S STATEMENT		
 Is prescribed medication Is prescribed medication Dosage/amount to be g Route of administration Frequency and time of a Duration (week, month, Diagnosis, intended effects, etc) Other requirements or s Other medication(s) stu Must this medication be to attend school or part Is supervised student se FOR ASTHMA/ANAPHYLAXIS N Is UNSUPERVISED self-a *Pursuant to Oklahoma asthma/anaphylaxis medica at school-sponsored activities 	iven administration fect, and anticipated react special circumstances dent is receiving administered during the scheicipate in school activities? _ elf-administration authorized MEDICATION ONLY dministration authorized? _ law, upon parental consection may possess and use helps without the supervision of	ion to medication (symptoms, side nool day in order to allow the student?
Physician Signature	Printed name	 Date
Physician's Address		Telephone Number