Lexington Public Schools

My student needs to carry/use an asthma inhaler or an anaphylaxis (Epi-Pen). ____ YES ____ NO

Parent/Guardian Authorization for Student to Self-Administer Asthma Medication

I, _____, hereby authorize, request and grant permission for Lexington Public Schools (District), to permit the self-administration of prescribed inhaled asthma medication(s) by my son, daughter or ward, _____ (student's name) according to the policy adopted by District's Board of Education. I further waive any claims against District, members of District's Board of Education, their agents and employees arising from the self-administration of said medication, and agree to hold harmless and indemnify District, the members of the Board of Education, their agents and employees, either jointly or severally, from and against any and all claims, liability demands, damages, causes of action, costs and expenses of any kind whatsoever, including attorney's fees, resulting, relating to or arising out of the self-administration of inhaled asthma medication as authorized herein.

I further agree to provide to District an emergency supply of student's inhaled asthma medication to be administered by the school nurse, county nurse, administrator or designated school employee. THIS AUTHORIZATION APPLIES TO ASTHMA MEDICATION **ONLY**.

I consent to my child's possession and unsupervised self-administration of prescribed inhaled asthma medication.

_____ _____

Parent/Guardian signature Date

_____

Address and Telephone number

In addition to this form, a Physician's Statement Self-Administration Consent Form MUST be on file before a student will be allowed to carry asthma medication.