

STAUNTON COMMUNITY UNIT SCHOOL DISTRICT NO. 6

Health Care Professional Request for Student Self-Administration of Asthma Medication

Name of Health Care Professional

Check One:

- ____ **Physician**
____ **Physician's Assistant***
____ **Advanced Practice Registered Nurse***

Name of Student

Birth date

Address

City, Zip

Telephone Number

TO:

Principal/Nurse: _____

School : _____

The above named student has asthma. I am requesting that the above named student take the following medication for the treatment of asthma during school hours:

Name of Medication

**Type of Medication
(Inhaler, Other)**

Dosage

Times to be given

Possible side effects

I certify that _____ has been instructed in the use
Name of Student
self-administration of _____

Name of Medicine

He/She understands the need for the medication, and the necessity to report to school personnel
any unusual side-effects. He/She is capable of using this medication independently.

I may be reached at the following number in the event of a reaction to the medication or in any
emergency.

Phone number of Health Care Professional

Signature of Health Care Professional

Address of Health Care Professional

Printed Name of Health Care Professional

***Physician's Assistants must have been delegated the authority to prescribe asthma medication by
their supervising physicians. Advanced practice registered nurses must have a written collaborative
agreement with a collaborating physician delegating the authority to prescribe asthma medication.**