FFAC Exhibit A

Aledo Independent School District

AUTHORIZATION FOR SELF-ADMINISTRATION OF ASTHMA
AND/OR ANAPHYLAXIS MEDICATION

Name of student _____ Grade _____

Name of parent _____

Parent's contact information _____

Prescribing health-care provider _____

Contact information for the prescribing health-care provider _____

_____

Description of condition/reason for medication _____

_____

Prescribed medication and dosage _____

How/when the medication should be used at school *(dosage, method, times)* _____

_____

Anticipated length of treatment _____

Possible adverse reaction _____

_____ *(student's name)* has asthma and/or anaphylaxis and is treated with prescription medication. *(He)(She)* is capable of administering *(his)(her)* own medication at school and at school-related or school-sponsored activities. The District will be informed of any changes to the medication specified on this form, to the dosage, or to the recommended regimen by an updated version of this consent form.

Parent _____ Date _____

Health-care provider _____ Date _____