Bastrop
Independent School District

PERMISSION TO CARRY AN ASTHMA INHALER

Student's Name: _____ Birthdate: _____Student ID:_____

Name of the school your student attends_____

The above named student has asthma and is capable of self administering the prescription asthma medication as described below:

Name of Medication: _____

Purpose of Medication: _____

Dosage: _____

Times and Circumstances under which medication may be administered:_____

Period of time for which medication is prescribed: _____

_____ _____
Physician's Signature Date

I authorize my child to self administer his/her prescription asthma inhaler as per doctor's orders while on school property or at a school-related event or activity. I understand that my child is responsible for the proper handling and carrying of the inhaler and that it must be kept out of the reach of other students at all times. The inhaler must have a current prescription label indicating that it has been prescribed for my child.

_____ _____
Parent Signature Date

Please return this from to the campus your student attends.