PERMISSION FORM FOR SELF-ADMINISTRATION OF ASTHMA MEDICATION BY STUDENTS

I,, he	ereby grant permission for my child,
, to self-administer h	nis or her asthma medication at school.
I understand that the Jackson Pub	lic School District by law shall incur no
liability on any claims relating to the self	-administration of asthma medications
by my child. I further agree to indemnify	and hold harmless the Jackson Public
School District and its employees agai	nst any claims relating to the self-
administration of asthma medication by m	y child.
health care practitioner,	indicating that ho/sho has
asthma and has been instructed in the se	
the name and purpose of the medication	and their prescribed dosage, the time
the medication are to be regularly adn	ninistered and under what additional
special circumstances the medications ar	e to be administered, if any, and the
length of time for which the medications a	re prescribed.
I understand that this permission for	orm is only effective for the school year
in which it is granted and that I must renew it each school year hereafter.	
S	IGNED
_	
Ā	DDRESS
P	HONE NUMBER
_ D	ATE

SOURCE: Jackson Public School District, Jackson, Mississippi

DATE: October 20, 2003

REVIEWED: August 10, 2017