GCSD Health Services Asthma Authorization Form

GCSD 4/2025

This section must be completed by **Licensed Medical Provider** only: Please Print

Student Name:	**Birthdate:**
List **Known Allergies** and/or **Asthma Triggers** include:	
Usual asthma symptoms include but not limited to:	
Prescribed Rescue Medication:	**Spacer Recommended**: No ☐ Yes ☐

Prescribed Frequency and Dose :

☐ As Needed for Rescue Treatment Give _____ Puffs

☐ Before PE/Recess/Strenuous Activity Dose; Give _____ Puffs (Scheduled Doses should be 4 hours apart)

☐ Sick Plan: Scheduled Rescue Treatment Give _____ Puffs every _____ hours and before PE/Recess/Strenuous Activity

It is the responsibility of the parent to notify the school nurse if the student is on a sick plan & for how long.

For Rescue Treatment:

1. Observe student for twenty minutes after rescue medicine administration or until breathing difficulties are relieved.
2. If student is still experiencing breathing difficulties after 20 minutes:
   IT IS ☐ **or** IS NOT ☐ okay to repeat rescue treatment dose for up to a total of ____times to relieve breathing difficulties.

Daily Asthma Control Medication(s) prescribed for **at home** use**:**

Student has permission to self-carry / self-administer this medication: ☐ **No** ☐ **Yes – if yes, read the following carefully:**

If yes box is checked, I agree that this student must be allowed to have the above-named medication/procedure on his/her person during school hours, in transit to and from school or school-sponsored activities, before and after-school activities on school property, and any school sponsored activity. **This child has demonstrated competency in self-monitoring and self-administration of this medication/procedure.** The parent is aware that they cannot hold the school district responsible for any adverse outcome of this action.

Printed Name of Licensed Medical Provider: _____ Phone: _____

Licensed Medical Provider Signature: _____ **Date**: _____

Parents / Legal Guardians Please Read Carefully: *By signing below, I understand and agree to the following*:

- I understand that all prescribed medications must be in the original container issued by the pharmacist with the most recent prescription label.
- I will notify the school when the medication is discontinued or the dosage changes.
- I give permission for the principal, school nurse(s), and/or health services to share this information with individuals who have responsibility for my child.
- I give GCSD Health Services my permission to contact the prescribing Licensed Medical Provider and prescribing pharmacy in relation to this prescription medication.
- I am responsible for replacing medication before the expiration date.
- I give my permission for designated GCSD staff to administer this medication to my child according to district requirements.
- The school district and its employees and agents are not liable for an injury arising from administration of medication authorized by an ICHP (care plan) / licensed medical provider.
- The parent/guardian shall indemnify and hold harmless the district and its employees and agents against a claim arising from administration of medication authorized by an IHP (care plan) / licensed medical provider.

My student has orders from our health care provider to Self-Carry/Self-Administer this medication:

☐ ***No*** ☐ ***Yes *If yes, read the following carefully:***

*Working closely with our physician we have decided to allow my child to self-administer and self-monitor the above medication while at school.

My child has been trained by our physician and has demonstrated competency in this procedure. My child must be allowed to possess this medication at school sponsored activities, in transit to and from school or school-sponsored activities, and during before or after-school activities on school property. I realize that the School District of Greenville County cannot be held responsible for any adverse outcome of this action. I am responsible for replacing expired medication before the expiration date. I will provide the medication in the original container, clearly labeled with my child's name. I will notify the school immediately if the medication is discontinued or the dosage has been changed. Permission is granted to the principal and/or school nurse to share this information with individuals who have responsibility for my child. The first dose will be given at home so that I can monitor adverse reactions. I give the school nurse my permission to contact the physician's office to request medical information concerning my child. *The school district and its employees and agents are not liable for an injury arising from a student's self-monitoring or self-administration of medications. The parent/guardian shall indemnify and hold harmless the district and its employees and agents against a claim arising from a student's self-monitoring or self-administration of medication.*

Parent/Legal Guardian Printed Name: _____ Daytime Phone Number: _____

Parent/Legal Guardian Signature: _____ **Date**: _____

**This form is only valid if signed on or after June 1st for the upcoming school year. **