



MIDLAND INDEPENDENT SCHOOL DISTRICT  
HEALTH SERVICES DEPARTMENT

**Physician Permission for Student to  
Carry and Self-Administer ASTHMA MEDICATION**

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Homeroom Teacher: \_\_\_\_\_ Grade/Student ID#: \_\_\_\_\_

Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_

PRINT Parent /Guardian First and Last Name \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_

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Physician Please Check:

\_\_\_\_\_ It is my professional opinion that \_\_\_\_\_  
should be allowed to carry and self-administer the following medication(s) at school or school  
related events for management of his/her asthma. This student has been instructed in the  
proper way to use his/her medication(s) and understands that these medications cannot be  
shared with any other person.

Medication Name: \_\_\_\_\_ Dose: \_\_\_\_\_

When to use: \_\_\_\_\_

How often can medication be repeated? \_\_\_\_\_

Additional instructions: \_\_\_\_\_

Physician Signature: \_\_\_\_\_

Print Physician's Name: \_\_\_\_\_

Date: \_\_\_\_\_ Office #: \_\_\_\_\_ Fax #: \_\_\_\_\_