



Olton ISD

Self Administration Release Form for Inhalers

Student's Name: _____ DOB: _____ Grade: _____

Homeroom Teacher: _____

I acknowledge that my child, _____, has been instructed on the proper use of the following

medication(s): _____.

I acknowledge that my child understands the possible side effects of taking this medication and knows what to do if side effects were to appear.

_____ Myself, along with my child's physician, request that my child be permitted to keep his/her medication on his/her person or locker while at school as we consider him/her responsible.

I understand that a new form must be completed each school year. I agree to notify the school nurse of any changes in medication(s) as soon as possible.

_____ My child should not be permitted to keep his/her medication on his/her person while at school and is to see the nurse if medication is needed.

Parent/Guardian Name

Parent/Guardian Signature

Date

Physician Name

Physician Signature

Date