



Challenge Charter School

An Official Core Knowledge School

Greg Miller • CEO • Principal



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Self Carry Medication Form

Today's Date: _____
Student's Name: _____ Date of Birth: _____ Age: _____
Teacher: _____ Grade: _____
Parent/Guardian's Name: _____ Home Phone: _____
Work Number: _____ Cell: _____ Other: _____

TO BE COMPLETED BY PARENT:

I request that my child, _____, may be permitted to carry or keep the medication in his possession as we consider him responsible. The student has been instructed in, understands the purpose, appropriate method, and frequency of use of his Inhaler. It is the responsibility of my student to ensure that he is always aware of the location of his inhaler, that it is stored to ensure no other students will have intentional or accidental access to such medication and that no other student will be allowed access by my student. I release Challenge Charter School from any liability in the administration of, or anything resulting from the administration of, this inhaler, as it will be under the control of my student.

Parent Signature: _____ Date: _____

Student Signature: _____ Date: _____

**This form is to be completed in addition to the Prescription Medication Form.*

TO BE COMPLETED BY PHYSICIAN:

I request that the above-named student be allowed to self-administer the following medication(s) for Asthma.

Name of Medication: _____

Dose Frequency: _____

Length of Use: _____

Prescribing Physician Signature: _____ Date: _____

Prescribing Physician Name: (Print) _____

Address: _____

Phone: _____ Date: _____

TO BE COMPLETED BY SCHOOL:

Approved

Principal Signature: _____ Date: _____