Gavin South
Middle School

25775 W. Highway 134
Ingleside, IL 60041

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Parent / Student Agreement to Carry Asthma Medication

I give permission, for my child_____to carry the medication described below. I understand that he / she must follow the rules listed below. I will notify the school of any changes in the medication.

NAME OF MEDICATION_____

DOSAGE_____

TIME OF ADMINISTRATION_____

IF PRN STATE TIME BETWEEN DOSES_____

START DATE_____

END DATE_____

Parent / Guardian Signature_____ Date_____

I,_____student at Gavin School District 37, agree to the following:

1. **I agree to never share my asthma medication with another person.**
2. **I agree to notify a teacher or other responsible adult if there is no improvement with my breathing after prescribed dosage.**

Student Signature_____ Date_____