AUTHORIZATION-ASTHMA, AIRWAY CONSTRICTING, OR RESPIRATORY DISTRESS MEDCICATION SELF-ADMINISTRATION CONSENT FORM

_____	___/___/___	_____	___/___/___
Student's Name (Last), (First) (Middle)	Birthday	School	Date

The following must occur for a student to self-administer asthma medication, bronchodilator canisters or spacers, or other airway constricting disease medication or for a student with a risk of anaphylaxis to self-administer an epinephrine auto-injector:

- Parent/guardian provides signed, dated authorization for student medication self-administration.
- Physician/guardian provides a written statement from the student's licensed health care professional (A person licensed under chapter 148 to practice medicine and surgery or osteopathic medicine and surgery, an advanced registered nurse practitioner licensed under chapter 152 or 152E and registered with the board of nursing, or a physician assistant licensed to practice under the supervision of a physician as authorized in chapters 147 and 148C) containing the following:
    - Name purpose of the medication,
    - Prescribed dosage, and
    - Times or special circumstances under which the medication or epinephrine auto-injector is to be administered.
- The medication is in the original, labeled container as dispensed or the manufacturer's labeled container containing the student name, name of the medication, directions for use, and date.
- Authorization is renewed annually. In addition, if any changes occur in the medication, dosage or time of administration, the parent is to notify school officials immediately. The authorization shall be reviewed as soon as practical.

Provided the above requirements are fulfilled, the school staff shall permit the self-administration of medication by a student with asthma, respiratory distress, or other airway constricting disease or the use of an epinephrine auto-injector by a student with a risk of anaphylaxis while in school, at school-sponsored activities, under the supervision of school personnel, and before or after normal school activities, such as while in before-school or after-school care on school-operated property. If the student abuses the self-administration policy, the ability to self-administer may be withdrawn by the school or discipline may be imposed, after notification is provided to the student's parent.

Pursuant to state law, the school district or and its employees are to incur no liability, except for gross negligence, as a result of any injury arising from self-administration of medication or use of an epinephrine auto-injector by the student. The parent or guardian of the student shall sign a statement acknowledging that the school district is to incur no liability, except for gross negligence, as a result of self-administration of medication or an epinephrine auto-injector by the student as provided by law.

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Medication	Dosage	Route	Time

Purpose of Medication & Administration /Instructions

Special Circumstances

Discontinue/Re-Evaluate/ Follow-up Date

Prescriber's Signature

Date

Prescriber's Address

Emergency Phone

- I request the above-named student possess and self-administer asthma medication, bronchodilators canisters or spacers, or other airway constricting disease medication(s) and/or an epinephrine auto-injector at school and in school activities according to the authorization and instructions.
- I understand the school district and its employees acting reasonably and in good faith shall incur no liability for any improper use of medication or an epinephrine auto-injector or for supervising, monitoring, or interfering with a student's self-administration of medication or use of an epinephrine auto-injector. I acknowledge that the school district is to incur no liability, except for gross negligence, as a result of self-administration of medication or use of an epinephrine auto-injector by the student.
- I agree to coordinate and work with school personnel and notify them when questions arise or relevant conditions change.
- I agree to provide safe delivery of medication and equipment to and from school and to pick up remaining medication and equipment.
- I agree the information is shared with school personnel in accordance with the Family Education Rights and Privacy Act (FERPA) and any other applicable laws.
- I agree to provide the school with back-up medication approved in this form.
- Student maintains self-administration record. ***(Note: This bullet is recommended but not required.)***

Parent/Guardian Signature
(agreed to above statement)

Date

Parent/Guardian Address

Home Phone

Business Phone

Self-Administration Authorization Additional Information