



**AUTHORIZATION – ASTHMA OR OTHER AIRWAY CONSTRICTING DISEASE
MEDICATION OR EPINEPHRINE AUTO-INJECTOR SELF-ADMINISTRATION CONSENT FORM**

Student Name _____ Grade _____

Medication _____ Dosage _____

Purpose for Medication (Health Condition) _____

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

- Parent/legal guardian provides signed, dated authorization for student medication self-administration.
- Parent/legal 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 and purpose of the medication or epinephrine auto-injector
 - Prescribed dosage
 - 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 shall be 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 shall permit the self-administration of medication by a student with asthma of 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 If the student abuses the self-administration policy, the ability to self-administer may be withdrawn by the school or discipline may be imposed, after notification is provided to the student’s parent/legal guardian.

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

Medication _____ Dosage _____

Purpose for Medication (Health Condition) _____

Administration/Instructions _____

Special Circumstances: _____

Discontinue/Re-Evaluate/Follow-Up Date _____

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Prescriber's Signature _____

Date _____

Prescriber's Address _____

Emergency Phone _____

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- I request the above-named student possess and self-administer asthma 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 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 district shall 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/from school and to pick up remaining medication and equipment.
- I agree the information is shared with school personnel in accordance with the Family Educational 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 shall maintain self-administration records.

Parent/Legal Guardian Signature _____

Date _____

Parent/Legal Guardian Address _____

Home Phone _____

Cell Phone _____

Work Phone _____

Additional Self-Administration Authorization Information _____
