Central Springs Community School District

Authorization For Asthma or Airway Constricting Medication Self-Administration

_____ ___/___/___ _____ _____

Student's Name Birthdate Grade Date

In order for a student to self-administer medication for asthma or any airway constricting disease:

- Parent/Guardian provides signed, dated authorization for student medication self-administration
- Physician, Physician Assistant, or Nurse Practitioner provides written authorization containing: (1) Name of Medication; (2) Prescribed dosage; (3) Times; (4) Special circumstances under which the medication is to be administered.
- The medication is in the original, labeled container as dispensed or the manufacturer's label containing the student's name, name of medication, direction for use, and date.
- Authorization is renewed annually. If any changes occur in the medication, dosage, or time of administration, the parent/guardian is to notify school officials immediately.

Provided the requirements are fulfilled, as student with asthma or other constricting disease may possess and use the student's medication 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 If the student abuses the use of the self-administration medication, the ability to self-administration may be withdrawn by the school may be imposed.

The parent/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 by the student as established by Iowa Code 280.16

- I request named student possess and self-administer asthma or other airway constricting disease medication(s) at school and in school activities according to the authorization and instructions.
- I understand that Central Springs School District and its employees acting reasonably and in good faith shall incur no liability for any improper use of medication or for supervising, monitoring, or Interfering with a student's self-administration of medication.
- 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.

Medication_____Dosage_____Route_____Time_____

Purpose of Medication and Administration Instruction:_____

Special Circumstances:_____

Parent/Guardian Signature (I agree to the above statements): _____

Parent/Guardian Home Address: _____Phone: _____

Prescriber's Signature:_____ Date:_____

Prescriber's Address: _____ Phone: _____

Additional Information: _____