AUTHORIZATION-ASTHMA OR AIRWAY CONSTRICTING MEDICATION SELF-ADMINISTRATION CONSENT FORM

I am the parent/guardian/custodian of_____ (student's full legal name), date of birth _____ in the _____ Building in the Ogden Community School District.

In order for a student to self –administer medication for asthma or other airway constricting disease.
Ex: Life Threatening Allergies that require an Epi-Pen.

Parent/guardian must provide a signed, dated authorization for student medication self-Administration.

* **Physician (person licensed under chapter 148, 150 or 150A), physician's assistant, advanced registered nurse practioner, or other person licensed or registered to distribute or dispense a prescription drug or device in the course of professional practice in Iowa in accordance with section 147, 107 or a person licensed by another state in a health field in which, under Iowa law, licensees in this state may legally prescribe drugs), must provide written authorization containing:**

  + **purpose of the medication,**

  + **prescribed dosage,**

  + **times or;**

  + **special circumstances under which the medication is to be administered.**

The medication must be in the original, labeled container as dispensed or the manufacturer's labeled container containing the student's name, name of the medication, directions for use and date.

Authorization must be renewed annually. 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, a student with asthma or other airway constricting disease may possess and use the student's medication while at school, at school-sponsored activities and before and after normal school activites, such as while in before-school or after-school care on school 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 If the student abuses the self-administration policy, the ability to self-administer may be withdrawn by the school or discipline may be imposed.

Pursuant to state law, the school district and its employees are to incur no liability, except for gross Negligence, as a result of any injury arising from self-administration of medication by the student. The parent or guardian of the student shall sign a statement acknowledging that school district is to Incur no liability, except for gross negligence, as a result of self-administration of medication by the Student as established by *Iowa Code 280.16.*

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_____ _____ _____ _____

Medication **Dosage** **Route** **Time**

_____

Purpose of Medication & Administration Instructions

_____ _____

Special Circumstances **Discontinue or Re-Evaluate Date (mark which)**

_____ _____

Prescriber's Signature **Date**

_____ _____

Printed Name **Emergency Phone**

Prescriber's Address

I request the above-named student possess and self-administer asthma or other airway constricting medication(s) at school and in school activities according to the authorization and instructions.

I understand the Ogden Community 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 timely provide safe delivery of medication and equipment to and from school and to timely pick up remaining medication and equipment.

I agree to provide the school with back-up medication approved by this form.

_____ _____

Parent/Guardian Signature **Date**

Parent/Guardian Address:

_____

_____

_____

_____ _____

Home Phone **Business or Cell Phone**