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

Student's Name (Last, First, Middle)	Birthdate	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.

Parent/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,
- 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, 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 If the student abuses the self-administration policy, the ability to self-administer may be withdrawn by the school or discipline may be imposed, after notification is provided to the student's parent.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 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 by the student as established Iowa Code § 280.16.

AUTHORIZATION ASTHMA OR AIRWAY CONSTRICTING, OR RESPIRATORY DISTRESS MEDICATION
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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. 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 (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.

PARENTAL AUTHORIZATION AND RELEASE FORM FOR THE ADMINISTRATION OF PRESCRIPTION MEDICATION TO STUDENTS

Student's Name (Last, First, Middle) _____ Birthdate _____

School _____ Date _____

School medications and health services are administered following these guidelines:

- Parent has provided a signed, dated authorization to administer medication and/or provide the health service.
- The medication is in the original, labeled container as dispensed or the manufacturer's labeled container.
- The medication label contains the student's name, name of he medication, directions for use, and date.
- Authorization is renewed annually and immediately when the parent notifies the school that changes are necessary.

Medication/Health Care _____ Dosage _____ Route _____ Time at School _____

Administration Instructions _____

Special Directives, Signs to Observe and Side Effects _____

Discontinue/Re-Evaluate/Follow-up Date _____

Physician Signature _____ Date _____

Physician Address _____ Emergency Phone _____

I request the above-named student carry medication at school and school activities, according to the prescription, instructions, and a written record kept. Special considerations are noted above. The information is confidential except as provided to the Family Education Rights and Privacy Act (FERPA). I agree to coordinate and work with school personnel and prescriber when questions arise. I agree to provide safe delivery of medication and equipment to and from school and to pick up remaining medication and equipment.

PARENTAL AUTHORIZATION AND RELEASE FORM FOR THE ADMINISTRATION OF PRESCRIPTION MEDICATION TO STUDENTS

Parent/Guardian Signature _____ Date _____

Parent/Guardian Address _____ Home Phone _____

Business Phone _____

PARENTAL AUTHORIZATION AND RELEASE FORM FOR THE ADMINISTRATION OF NON-PRESCRIPTION MEDICATION TO STUDENTS NAMELY TYLENOL OR IBUPROFEN

Board Policy 507.02E1

The undersigned are the parent(s), guardians(s) or person(s) responsible for

_____ _____
Student's Name (Last, First, Middle) Grade

Attendance Center:

❒ GLR Elementary ❒ GLR Middle School ❒ GLR High School

❒ Tylenol ❒ Ibuprofen _____ Dosage/mg.

Beginning on _____ and continuing through_____
Date Date

_____
Special Instructions to Medication Administrator

Person(s) authorized to administrator medication:

_____ _____
Parent/Guardian (PRINT NAME) Date

_____ _____
Parent/Guardian (SIGNATURE) Home Phone

_____
Alternate Phone Number