Montana Authorization to Carry and Self-Administer Asthma Medication

For this student to carry and self-administer asthma medication on school grounds or for school sponsored activities, this form must be fully completed by the prescribing physician/provider and an authorizing parent or legal guardian.

Student's Name: _____ School: _____
Sex: (Please Circle) Female / Male City/Town: _____
Birthdate: ____ / ____ / _____ School Year: _____ (Renew each year)

Physician's Authorization:
The above named student has my authorization to carry and self-administer the following medication:
Medication: (1) _____ Dosage: (1) _____

(2) _____ (2) _____

Reason for prescription(s): _____

Medication(s) to be used under the following conditions: _____

_____

I confirm that this student has been instructed in the proper use of this medication and is able to self-administer this medication on his/her own without school personnel supervision. I have provided a written treatment plan for managing asthma or anaphylaxis episodes and for medication use by this student during school hours and school activities.

_____ _____ _____
Signature of Physician Physician's Phone Number Date

Backup Mediation -- The law prohibits that if the child's health care provider prescribes "backup" medication to keep at the school, it must be kept in a predetermined location, known to the child, parent and school staff.

The following Backup Medication has been provided for this student: _____

For Completion by Parent or Guardian

- As the parent/guardian of the above named student, I confirm that this student has been instructed by his/her health care provider on the proper use of this/these medication(s). He/she has demonstrated to me that he/she understands the proper use of this medication. He/she is physically, mentally, and behaviorally capable to assume this responsibility. He/she has my permission to self medicate as listed above if needed. If he/she has used an auto-injectible epinephrine, he/she understands the need to alert an adult that emergency personnel need to be called. If he/she has used his/her asthma inhaler as prescribed and does not have relief from an asthma attack, he/she understands to alert an adult.
- I also acknowledge that the school district or nonpublic school may not incur liability as a result of any injury arising from the self-administration of medication by the pupil and that i shall indemnify and hold harmless the school district or nonpublic school and its employees and agents against any claims, except a claim based on an act or omission that is the result of gross negligence, willful and wanton conduct, or an intentional tort.
- I also agree to work with the school district in establishing a plan for use and storage of backup medication is prescribed, as above, by my child's physician. This will include a predetermined location to keep back up medication to which my child has access in the event of an asthma or anaphylaxis emergency.
- Authorization is hereby granted to release this information to appropriate school personnel and classroom teachers.
- I understand in the event that the medication dosage is altered, a new "self-administration form" must be completed, or the physician may re-write the order on his prescription pad and I, the parent/guardian, will sign the new form and assure the new order is attached.
- I understand it is my responsibility to pick up any unused medication at the end of the school year, and that the medication that is not picked up will be disposed of.

Parent/Guardian Signature: _____ Date: _____

(*Original signed authorization to the school; a copy of signed authorization to the parent/guardian and health care provider*) 06/05