USD 470 ARKANSAS CITY PUBLIC SCHOOLS

AUTHORIZATION FOR SELF ADMINISTRATION FOR EMERGENCY ASTHMA/ALLERGY MEDICATIONS

PART A

Parent/legal Guardian to Complete

Name of Student: _____ Date of Birth: _____ School: ____ Grade/Teacher ___

The above student has been instructed on self-administration of medication, and I hereby give my permission for him/her to administer at school as ordered the medication(s) listed below. I understand that it is my responsibility to furnish this medication. I acknowledge that the school incurs no liability for any injury resulting from the self-administration of medication and agree to indemnify and hold the school, and its employees and agents, harmless against any claims relating to the self-administration of such medication.

I also acknowledge the need and give permission for appropriate communications between the school health professional and the medical prescriber related to the specific treatment in question, including communication concerning: 1. The prescription or treatment itself (e.g. questions regarding dosage, method of administration, implementation of the treatment in school (e.g., questions regarding safety concerns, infection control issues, or outcomes from the treatment (e.g., questions regarding observed side effects, possible untoward reactions, observations of behavior changes in the classroom); 4. And other pertinent issues related to the student's diagnosis, condition, or treatment.

_____ _____ _____

Parent/Legal Guardian Signature Printed Name Today's Date

PART B: *PHYSICIAN TO COMPLETE*

Medication/Treatment	Purpose	Dosage	Time/Frequency
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Conditions & Special Circumstances for use: _____

Length of time medication is to be administered: _____

_____ _____ _____

Physician Signature Printed Name Today's Date

_____

Physician Phone Number and Fax Number

PART C: School Nurse to Complete: School Nurse Review of order and procedure with the student. Completed _____