Code: <u>517.2</u> Page 1 of 2

Title:	Authorization-Asthma or Airway Constricting Disease Medication Self-Administration Consent Form				
		/ /		/ /	
Studen	t's Name (Last), (First) (Mid	dle) Birthday	School	Date	
In orde	er for a student to self-adm	ninister medication f	or asthma or any a	irway constricting	
•	Parent/guardian provides self-administration.	signed, dated autho	rization for studen	t medication	
•	Prescriber (person licensenurse practitioner, or other prescription drug or deviewith section 147.107, or under Iowa law, licensee authorization containing:	er person licensed or ce in the course of p a person licensed by s in this state may le	registered to distr rofessional practice another state in a gally prescribe dru	ibute or dispense a e in Iowa in accordance health field in which,	
	 Name and purpose of the medication, 				
	 prescribed dosage times or special c administered; 		which the medicati	ion is to be	
•	The medication is in the labeled container contain use (including the time o date.	ing the student name	e, name of the med	ication, directions for	
•	Authorization is renewed of the medication, the pa shall be reviewed as soon	rent is to notify scho			
construschool norma proper	led the above requirements icting disease may possess sponsored activities, under a school activities, such as ty. If the student abuses the hdrawn by the school or disease.	and use the student er the supervision of while in before-sch e self-administration	's medication while school personnel, ool or after-school policy, the ability	e in school, at and before or after care on school-operated	
gross i studen school	ant to state law, the school negligence, as a result of a at. The parent or guardian of district is to incur no liab liministration of medication	ny injury arising fro of the student shall s ility, except for gros	m self-administrati ign a statement ack s negligence, as a r	ion of medication by the knowledging that the result of	
Medic	ation Dosage	Route		Time	

Purpose of Medication & Administration /Instructions

Code: <u>517.2</u> Page 2 of 2

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 constricting disease medication(s) at school and in authorization and instructions. I understand the school district and its employees a shall incur no liability for any improper use of medicationing, or interfering with a student's self-admacknowledge that the school district and its employ for gross negligence, as a result of any injury arising medication by the student. I agree to coordinate and work with school personarise or relevant conditions change. I agree to provide safe delivery of medication and epick up remaining medication and equipment. I agree the information is shared with school personal Education Rights and Privacy Act (FERPA) and other interest of the school with back-up medicated. 	school activities according to the cting reasonably and in good faith lication or for supervising, inistration of medication. I rees are to incur no liability, except ag from self-administration of medication of medication and notify them when questions requipment to and from school and to medicate a manufacture with the Family her laws as may be applicable.	
Parent/Guardian Signature (agreed to above statement)	Date	
Parent/Guardian Address	Home Phone	
	Business Phone	

Revised: April 26, 2011 May 10, 2016 Reviewed: April 27, 2021 Approved: May 23, 2006

Self-Administration Authorization Additional Information